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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 0 5 0  
REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ERNEST F. CURETON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 - 11 - 86</b>			2b. HOUR <b>12 45</b> M	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 13 35</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>usa</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>636 N. Gilmore St 21217</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest M. L. Cureton</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Tinkler</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>215-30-0131</b>		17. INFORMANT ADDRESS <b>Christine Barbour 4314 Norfolk Ave</b>			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RESPIRATORY FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(b) **PULMONARY TUBERCULOSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

**MALNUTRITION**

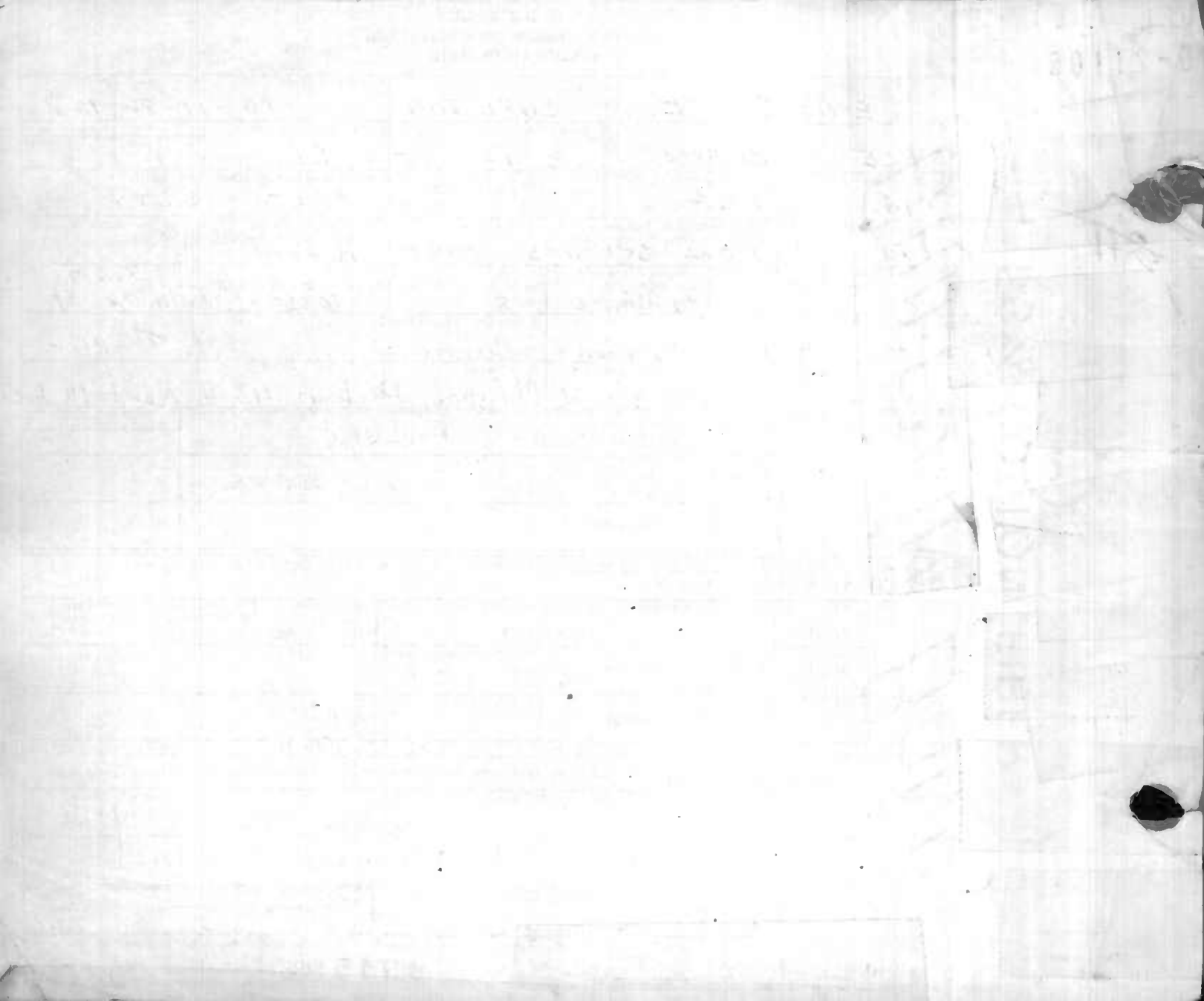
9a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NA</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NA</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, BARN, ETC.) <b>NA</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NA</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-9-</b> 19 <b>86</b> , to <b>10-11-</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>10-11-</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Surgeon - Ambo</b>				DEGREE		22c. DATE SIGNED <b>10/11/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SURVIT S JULKA</b>				22e. ADDRESS <b>BON SECOURS HOSPITAL</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/17/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Vet</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>OWINGS Mills Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>March Funeral Home West 4300 Wabash Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1986</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return carbon copies of pages 1 and 2 to the funeral director. Page 4 should be retained by the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic and significant event, the death certificate should be completed in detail.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AMY CUSHING			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 30, 1986			2b. HOUR 7:58 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 14, 1986		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 16		7. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -----		12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 827 Brunswick Road Apt. 1A 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Paul R. Cushing			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melanie Rae Deffinbaugh							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----		17. INFORMANT Paul R. Cushing				ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>STAPH. AUREUS SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours 8 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>PREMATURITY - 25wk gestation infant</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>October 24</u> , 19 <u>86</u> , to <u>October 30</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>October 30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Howard Orel MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/30/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD OREL				22e. ADDRESS JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST BALT, MD 21205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/1/86		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.				
24. FUNERAL DIRECTOR Bruzdinski Funeral Home PA				25a. DATE REC'D. BY REGISTRAR NOV 5 1986		25b. REGISTRAR'S SIGNATURE John J. Padden-Randall				

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HSE Research Fund No. 7A

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• *Journal of Management Education*

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Doc. Inv. No.

25/01/20

Future

• by James G. Thompson

1. The first step is to identify the problem or question that needs to be answered.

0-20857

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES</b> <b>FRANCES</b>		FIRST <b>FRANCES</b> MIDDLE <b>GEORGINA</b> LAST <b>CUSHMAN</b> <b>Cushman</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10-10-86</b>		2b. HOUR <b>10<sup>25</sup> PM</b>	
3. SEX <b>FEMALE</b> <b>Female</b>		4. RACE <b>White</b> <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 03 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Balto.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Edgewood Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>335 Overbrook Rd. 21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elam</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Delia Veinot</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>062-095660</b>		17. INFORMANT ADDRESS <b>Mrs. B.R. Molony 335 Overbrook Road 21212</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 Hours</b>
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>Renal Failure, Congestive Heart Failure, Dementia</b>							
19a. DATE OF OPERATION <b>NA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <b>SEPTEMBER 1984</b> to <b>OCTOBER 10, 1986</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 10, 1986</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Patricia A. Savadel</b>		DEGREE <b>MD</b>		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED <b>10-11-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRICIA A. SAVADEL</b>		22e. ADDRESS <b>120 SR. PIERRE DR #105 TOWSON 21204</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>10-15-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>N. Yarmouth Cumberland Maine</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Road 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1986</b>	
25b. REGISTRAR'S SIGNATURE							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REMARKS: If item 21 is marked as item 18 allows any injury, or other traumatic event, to be the cause of death, the physician must be notified of this.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28037

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
George Custis			10 22 86			845 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Black	MONTH DAY YEAR 1 27 25		61 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
VIRGINIA	U.S.A.			Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	Francis Scott Key Hosp.							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
VIRGINIA		KELLER	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	P.O. Box 423 23401		99999		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Fred Custis			FIRST MIDDLE LAST Nannie Conquest					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
yes			228-42-7063		Maggie Custis Keller, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lung Mass</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 5</u> , 19 <u>86</u> , to <u>Oct 22</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Oct 22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>M. Fingerhood MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/22/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Fingerhood				22e. ADDRESS Francis Scott Key Med Ctr Balt. MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-26-86		23c. NAME OF CEMETERY OR CREMATORY Snead Methodist Cem. Keller, Va.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Leroy Dyett & Son				25a. DATE REC'D. BY REGISTRAR OCT 24 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

notified above.

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TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 allows any injury, or other traumatic event, the medical examiner must be notified above.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR **George J. Czyzewski** **CERTIFICATE OF DEATH**

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. **28040**

1. DECEASED NAME (TYPE OR PRINT) <b>George J. Czyzewski</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/20/86</b>		2b. HOUR <b>8<sup>01</sup> A.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 1 32</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supply Supervisor-HOSPITAL</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Czyzewski</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Adams</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> 16b. SOCIAL SECURITY NO. <b>213 280 288</b>
17. INFORMANT ADDRESS <b>8153 Park Haven Rd, Linda Rossmark, Dghtr, Balto, Md. 21222</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Undifferentiated lung cancer squamous cell</b> Diagnosed April 1986			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <b>October 14, 1986</b> to <b>October 20, 1986</b> that (I) (we) last saw the deceased alive on <b>October 20, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true, did not) view the body after death.						
22a. SIGNATURE <b>Shirley R. Medley MD</b>			DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/20/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SYLVIA R. MEDLEY</b>			22e. ADDRESS <b>2724 North Charles St. 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/22/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Luth.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aberdeen, Md.</b>
24. FUNERAL DIRECTOR NAME <b>SCHIMUNEK FUNERAL HOME, Balto, Md. 21218</b>		25. DATE REC'D. BY REGISTRAR <b>OCT 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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RECEIVED

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00-21270

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 28341  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E LAST DARE			2a. DATE OF DEATH MONTH DAY YEAR Oct 11 86			2b. HOUR 6 P.M.	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 21 1947		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK	
13a. STATE MD		13b. COUNTY BALT.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST JOHN MIDDLE R LAST BIVENS				15. MOTHER'S MAIDEN NAME FIRST GEORGIA MIDDLE LAST HATTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. 212473898		17. INFORMANT ADDRESS OLD CHART.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

30'

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypertension

3 hrs

DUE TO, OR AS A CONSEQUENCE OF

(c) Erosion of Tumor, Right Anteriorly causing Hypertensive Stroke

3 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CARCINOMA of Tongue / Floor of Mouth, Metastatic

19a. DATE OF OPERATION 11 Oct 86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Right Carotid Artery		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00 P.M. Oct 11 86		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 11 Oct 1986 to 11 Oct 1986, that (1) (we) lost saw the deceased alive on 11 Oct 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) we (we) (did not) view the body after death.							
22b. SIGNATURE PETER M. DALONI M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11 Oct 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER M. DALONI M.D.				22e. ADDRESS 2250 GREEN ST BAL MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME HENRY O. DUFF F.H. 4600 Liberty Hts ADDRESS				25a. DATE REC'D. BY REGISTRAR OCT 15 1986		25b. REGISTRAR'S SIGNATURE James H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes and signatures are visible across the page, including a large signature in the bottom left corner and various scribbles and markings throughout the document.

023520 NOV 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28042

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Everette		M.		Dashiell				10/31/1986								7:39 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	04 26 1986		29 YRS.						10/31/1986							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.										Baltimore City,				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		954 Forest St.															
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS											
Maryland		Wico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3 Wadonia Ave									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT											
James		Dashiell		213-70-9801		Laura F. Dashiell											
18a. WAS DECEASED EVER IN U.S. ARMED FORCES?		18b. SOCIAL SECURITY NO.		18c. CITY OR TOWN		18d. STREET ADDRESS											
N/A		N/A		213-70-9801		Laura F. Dashiell											
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Hanging											
				DUE TO, OR AS A CONSEQUENCE OF													
				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF									
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		7:00pm 10/31/1986		subject hanged self in jail cell													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		STREET		CITY OR TOWN		COUNTY		STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		jail cell		954 Forest St., Baltimore City, Md.													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		10/31/86											
Margarita A. Korell, M.D.		M.D. Assistant															
EXAMINER'S NAME		ADDRESS		111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		11-4-1986		Green Hill Cemetery		Salisbury		Wico		MD							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Russell A. Fiske		Salisbury, Md.				NOV - 5 1986		Julia Twidson, R.									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0582-11012



2009 COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon against Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William H. Davenport					2a. DATE OF DEATH MONTH DAY YEAR 10 27 86				
2b. HOUR 6 51 AM									
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 01 12 29		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Hospital Loch Raven				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Furniture finisher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1611 Dallas St. / 21205	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Holmes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Davenport					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 217-26-4592		17. INFORMANT ADDRESS Davis Clayton 1704 E. 29 <sup>th</sup> St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Ca From Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>86</u> , to <u>10/27</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>10/27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE Jeffrey Joe MD				22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22d. DATE SIGNED 10/27/86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey Joe, MD				22f. ADDRESS 225 Greene St. Dept. of Medicine, Baltimore, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/1/86		23c. NAME OF CEMETERY OR CREMATORY Basil AME Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cocoesville Md.			
24. FUNERAL DIRECTOR NAME Chatman-Norris FH 1701 McCulloh St.				25a. DATE REC'D. BY REGISTRAR NOV 2 1986		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall			





00-21890

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove this certificate from the envelope. Page 4 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRENE P. Davidson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/20/1986</b>		2b. HOUR <b>12:39</b> <small>am</small>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 7 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>12 39</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>700 Camberley Circle 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lester Poole</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Crowell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-09-3002</b>		17. INFORMANT ADDRESS <b>Mrs. Beyla Irene Kandalis Same as 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHOGENIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MINS</b> <b>10 MONTHS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/7</b> 19 <b>86</b> , to <b>10/20</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/19</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE <b>Jon R. Resar</b>		DEGREE <b>MD</b>		27c. DATE SIGNED <b>10/20/86</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JON R. RESAR</b>		27e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>10-20-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. 1050 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1986</b>		25b. REGISTRAR'S SIGNATURE	

BP

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00-20825

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a coroner's inquest may be required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 28043							
1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE DAVIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10/9/86</b>		2b. HOUR <b>2:30 A.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 25 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO, CO.</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINIA HOSP OF BALTIMORE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3604 MALDEN AVE 21211</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James David Davis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Killpatrick</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>251-09-4235</b>		17. INFORMANT <b>Etta E. Davis</b>		ADDRESS <b>Balto. Md 3604 Malden Avenue 21211</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> , 19 <b>86</b> , to <b>10/9</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>10/9</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Carol A. Freeland</b>				DEGREE		22c. DATE SIGNED <b>10/9/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CAROL A. FREELAND</b>				22e. ADDRESS <b>SINIA HOSP OF BALTO. Northern Blvd &amp; 21215 Belvedere Ave</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/13/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grand View Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Travlers Rest, Greenville Co, SC</b>			
24. FUNERAL DIRECTOR NAME <b>Burgee-Henss Funeral Home, 3631 Falls rd 21211</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1986</b>		25b. REGISTRAR'S SIGNATURE			



00-22088

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR	
James M. Davis								10 21 86		10 21 86		6 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. BALTIMORE CITY OR COUNTY OF DEATH		7d. HOUR	
MALE	WHITE	MARCH 25 1945		41 YRS.						Baltimore City		6 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH		11. BALTIMORE CITY OR COUNTY OF DEATH	
FLORIDA		U. S. A		WIDOWED		DIVORCED		Baltimore City		Baltimore City		Baltimore City	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS		13c. CITY OR TOWN	
Baltimore		Johns Hopkins Hospital		ENGINEER (BLDE)				YES		6112 54th AVE		RIVERDALE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH		19. DATE OF OPERATION	
THOMAS		LOUISE		NO		231-56-1951		JUANITA P. DAVIS		Gunsight wound of abdomen		1986	
20. CITY OR TOWN OF DEATH		21. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		22. DATE OF BIRTH		23. AGE (IN YEARS)		24. IF UNDER 1 YR.		25. IF UNDER 24 HRS.		26. HOUR	
Baltimore		Johns Hopkins Hospital		10 21 86		41 YRS.						6 AM	
27. BALTIMORE CITY OR COUNTY OF DEATH		28. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		29. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		30. KIND OF BUSINESS OR INDUSTRY		31. INSIDE CITY LIMITS?		32. STREET ADDRESS		33. CITY OR TOWN	
Baltimore City		Johns Hopkins Hospital		ENGINEER (BLDE)				YES		6112 54th AVE		RIVERDALE	
34. FATHER'S NAME		35. MOTHER'S MAIDEN NAME		36a. WAS DECEASED EVER IN U.S. ARMED FORCES?		36b. SOCIAL SECURITY NO.		37. INFORMANT		38. CAUSE OF DEATH		39. DATE OF OPERATION	
THOMAS		LOUISE		NO		231-56-1951		JUANITA P. DAVIS		Gunsight wound of abdomen		1986	
40. CITY OR TOWN OF DEATH		41. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		42. DATE OF BIRTH		43. AGE (IN YEARS)		44. IF UNDER 1 YR.		45. IF UNDER 24 HRS.		46. HOUR	
Baltimore		Johns Hopkins Hospital		10 21 86		41 YRS.						6 AM	
47. BALTIMORE CITY OR COUNTY OF DEATH		48. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		49. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		50. KIND OF BUSINESS OR INDUSTRY		51. INSIDE CITY LIMITS?		52. STREET ADDRESS		53. CITY OR TOWN	
Baltimore City		Johns Hopkins Hospital		ENGINEER (BLDE)				YES		6112 54th AVE		RIVERDALE	

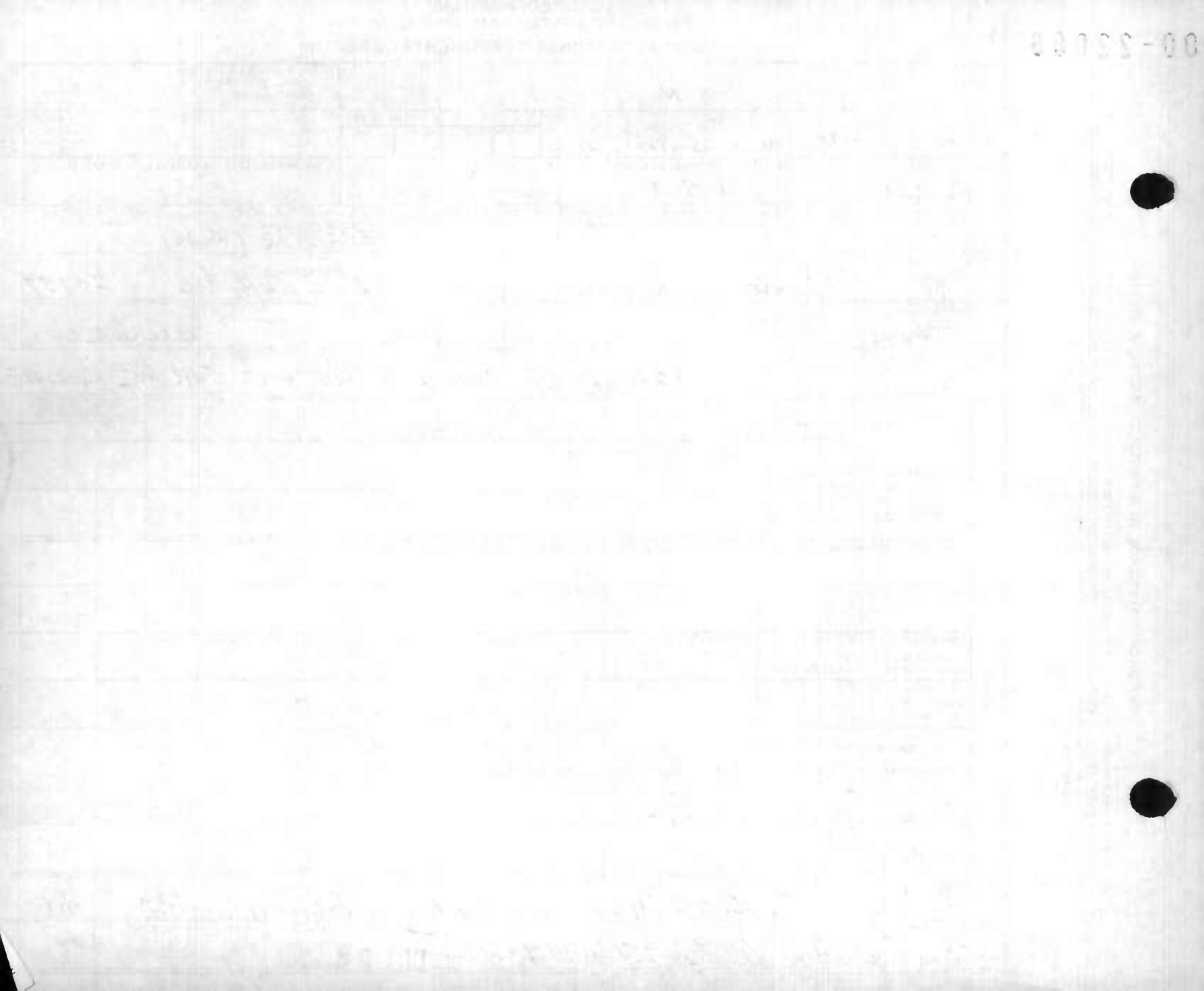
MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Gunshot wound of abdomen  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		3:10 P.M. 10 18 86		Subject shot	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		parking lot		700 Blk. President St., Baltimore City, MD.	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
<i>William M. Zane</i>		M.D. Assistant		10/21/86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
William M. Zane, M.D.		111 Penn St. Balto. MD.			

23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		Oct. 25. 1986		Fort Lincoln Cemetery		Baltimore		MD	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
Tolomeo Funeral Home		OCT 24 1986		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>	



00-21167

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be called at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 2 8 0 4 . 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH A. DAVIS			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1986		2b. HOUR M						
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 6 27		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 72 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.s.a.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1907 KENNEDY AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Motors		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1907 Kennedy Avenue 21218		
14. FATHER'S NAME FIRST MIDDLE LAST Bishop H.L. Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Bell Willis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] Yes			16b. SOCIAL SECURITY NO. 250307744		17. INFORMANT ADDRESS Teresa Peters 621 North Augusta Avenue						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. S. R. H. M. C. L.</u>			DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. S. R. H. M. C. L.			22e. ADDRESS 2115 W. Pratt St. - Baltimore 21222								
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial			23b. DATE 10/17/86		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Maryland				
24. FUNERAL DIRECTOR NAME March Funeral Homes					1101 East North Avenue		25a. DATE REC'D. BY REGISTRAR OCT 16 1986		25b. REGISTRAR'S SIGNATURE <u>Davidson</u>		

BP





100-51181-1

00-23003

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28043

1. DECEASED NAME (TYPE OR PRINT) Lena Davis			2a. DATE OF DEATH MONTH DAY YEAR 10/28/86			2b. HOUR 6:30A <sub>M</sub>			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1/16/97		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa St. Michael				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 645 N. Calhoun St. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST James Coleman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No		17. INFORMANT Dakota Robertson		17. ADDRESS 301 Eutaw Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>8/7</u> , 19 <u>89</u> , to <u>10/28</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arthur M. Lebson</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur M. Lebson, M.D.				22e. ADDRESS 3640 Fords Lane 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/3/86		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md			
24. FUNERAL DIRECTOR NAME March Funeral Home West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR 10/3-1986		25b. REGISTRAR'S SIGNATURE <u>Dakota Robertson</u>			

MEDICAL CERTIFICATION

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 4, 5, 6, and 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 3 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

00-22424

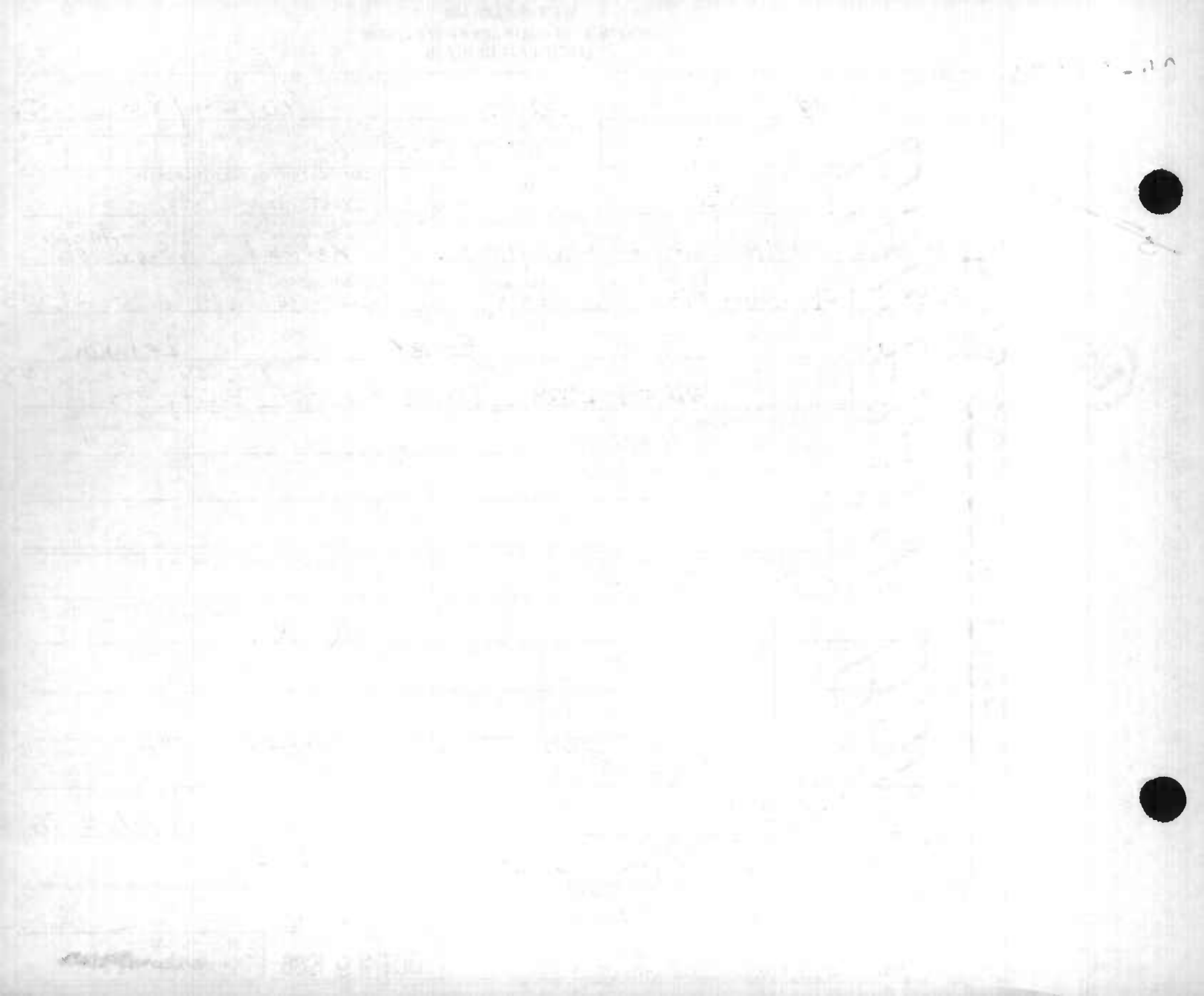
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 28049

1. DECEASED NAME (TYPE OR PRINT) Levi		FIRST MIDDLE LAST Davis		2a. DATE OF DEATH MONTH DAY YEAR 10/24/86		2b. HOUR 2:15 PM	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 07 04 02		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Sugar Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmer Lehmhor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 212-09-6028		17. INFORMANT Doris Alverta		ADDRESS 2628 W. Frank Lin St Balt, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urosepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 d
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Chronic Renal Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/21, 19 86, to 10/24, 19 86, that (I) (we) last saw the deceased alive on 10/24, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. BARR		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Univ. of Md. Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/30/86		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md	
24. FUNERAL DIRECTOR NAME March Funeral Home West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR OCT 29 1986		25b. REGISTRAR'S SIGNATURE	

BP



00-20983

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR AKA Caraker									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOLORES CAROLINE DAY					2a. DATE OF DEATH MONTH DAY YEAR 10-12-86			2b. HOUR 3-25 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 6 29		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assistant Manager Telephone co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland					13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 1225 Elmridge Avenue 21229		
14. FATHER'S NAME FIRST MIDDLE LAST Otto Kunert					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Buhl				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-24-8273		17. INFORMANT ADDRESS Chere Bosley 5518 Ashbourne Rd. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Poorly differentiated, adeno-carcinoma of the liver, primary unknown</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>October 9</i> , 19 <i>86</i> , to <i>October 12</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>October 12</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M. Isabelle MacGregor</i>					DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>10-12-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. ISABELLE MACGREGOR</i>					22e. ADDRESS <i>KESWICK 700 W 40th ST. BALTO. MD 21211</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/16/86		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229					25a. DATE REC'D. BY REGISTRAR <i>OCT 15 1986</i> 25b. REGISTRAR'S SIGNATURE				

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 8 0 5

1 DECEASED NAME (TYPE OR PRINT) <b>DANIEL WEBSTER DEAN, Sr.</b>			2a DATE OF DEATH MONTH DAY YEAR HOUR <b>10 7 86 3:15 PM</b>	
3 SEX <b>Male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>11 2 1902</b>	6 AGE (IN YEARS (LAST BIRTHDAY)) <b>83</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Paint Dept.-Glenn L. Martin</b>	
12b USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE <b>Md.</b> 12b COUNTY <b>BALTO</b> 12c CITY OR TOWN <b>Balto.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>Balto., Md. 733 Manchester Rd. #21229</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William H.</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Meekins</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>214-05-3214-A</b>		
17 INFORMANT ADDRESS <b>Mrs. Gertrude M. Dean</b>		17b ADDRESS <b>733 Manchester Rd.-Balto., Md. #21229</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Renal failure; hepatic failure</b>				
19a DATE OF OPERATION				
19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that I (this hospital) attended the deceased from <b>September 14 1986</b> to <b>October 7 1986</b> , that I (we) last saw the deceased alive on <b>October 7 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Barbara Socha</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/7/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARBARA Socha</b>		22e ADDRESS <b>St. Agnes Hospital, 900 Caton Ave, BAL.</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Oct. 11, 1986</b>	23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk. Cem.</b>	
24 FUNERAL DIRECTOR NAME <b>G. Truman Schwab</b>		24b ADDRESS <b>5151 BARTO. NAT'L. PIKE</b>	24c DATE REC'D. BY REGISTRAR <b>OCT 09 1986</b>	
25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

10455-

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0-22118

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM BERNARD DeBLOOM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 23, 1986</b>		2b. HOUR <b>10:30<sup>A</sup></b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12/30/20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>F.S. Key Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		13a. STATE <b>Md</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
13d. INSIDE CITY LIMITS? <b>Yes</b>		13e. STREET ADDRESS / ZIP CODE <b>3813 Fait Avenue 21224</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Willy DeBloom</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Nehus</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>W/W. 2 215-16-5336</b>		17. INFORMANT ADDRESS <b>Cecelia D. DeBloom 3813 Fait Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Diabetes Mellitus.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>10/24/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GP A. C. K. PATRICK</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/27/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION <b>Eastwood, Balto. Co. Md.</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Chas. S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1986</b>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP



00-22125

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and filed in his/her office within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in his/her office, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ELIZABETH MARGARET DEBOY								10/23/86		7:55A. M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		CAUC		6 MONTH DAY YEAR		65 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
BALTO. MD		USA				Baltimore City MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK - MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Baltimore		St. Agnes Hospital				Packer		Mary Sue Candy			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b STATE		13c COUNTY		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
MD		Baltimore		Arbutus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5112 Westland Blvd 21227			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
Henry		Freida		No		220054316		Peter F. DeBoy, 5112 Westland Boulevard 21227			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CARDIAC ARRYTHMIA - VENTRICULAR FIBRILLATION										1 HR.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MARKED CORONARY ATHEROSCLEROSIS										YRS.	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2							
		P.M. 19									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
James E. Taylor		M.D.				10/23/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
JAMES E. TAYLOR, M.D.		ST AGNES HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Entombment		10/27/86		Loudon Park Mausoleum		Baltimore				Maryland	
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Hubbard Funeral Home, Inc., 4107 Wilkens Ave.		21229									
OCT 24 1986											

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)



00-21330

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSIE H. DeFOE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 14 86</b>		2b. HOUR <b>9:08 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 6, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>3316 Gilman Ter. 21211</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred Henry Kellett</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Biggart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>062-10-0897A</b>		17. INFORMANT ADDRESS <b>Charles H. Heilman, 5923 Theodore Av.</b>		17b. ADDRESS <b>21214</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CNF. SEPSIS S/P CROSSL</b> DUE TO OR AS A CONSEQUENCE OF <b>REPEATED PUL BACTERIAL INFL</b> <b>REPEATED PUL BACTERIAL INFL</b> DUE TO, OR AS A CONSEQUENCE OF <b>REPEATED PUL BACTERIAL INFL</b> (c) <b>REPEATED PUL BACTERIAL INFL</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/30/86</b> to <b>10/14/86</b> , that (I) (we) lost saw the deceased alive on <b>10/13/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/15/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. OSEI-WU</b>		22e. ADDRESS <b>LIBERTY MD. CENTER</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Oct. 16, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 16 1986</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
6009 Harford Rd., Balto., Md. 21214							

RECEIVED





0-20116

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

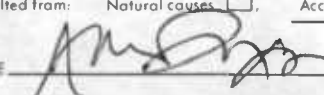
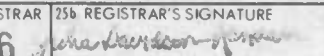
07/84  
25M

BP

DHMH - 17  
(VR A15 ME (1))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23055

1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT) TONY DELUCA Sr.										10-3-86		19		M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2-13-1912		6. AGE (IN YEARS) 74 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD 10-3-86		19		2d. HOUR 3:47P					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.A.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired/Produce				12b. KIND OF BUSINESS OR INDUSTRY Produce							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3929 E. Pratt St. 21224							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore															
14. FATHER'S NAME James Deluca Sr.										15. MOTHER'S MAIDEN NAME Mary Grace Diana									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 213-01-0634		17. INFORMANT ADDRESS 21040 Mrs. Clara Gross 1212 Janet Drive							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chest injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 1:55PM 10-3-86				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of a truck in collision (head-on) with another vehicle											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. CITY OR TOWN STATE Priestford Rd. & Trapp Church Rd. Harford Co., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER								DATE SIGNED 10-4-86							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-7-1986		23c. NAME OF CEMETERY OR CREMATORY Holly Hills Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland									
24. FUNERAL DIRECTOR NAME Joseph N. Zannino Jr.				ADDRESS 263 S. Conkling St				25a. DATE REC'D. BY REGISTRAR OCT 06 1986				25b. REGISTRAR'S SIGNATURE 							

17

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CONFIDENTIAL

SSIS 40 4450 . S

SECRET

YES      NO      YES      NO

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SJS-07-098

INSIDE - 000876

7-10-68

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00-22083

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Two please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
Item 13a.-13c. FOR STATE REGISTRAR <u>10-29-86 A.L.</u> REG. NO. <u>8028050</u>									
1 DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST <u>Dempsey Baby Boy</u>					2a DATE OF DEATH MONTH DAY YEAR <u>OCTOBER 11, 1986</u>		2b HOUR <u>4:46am</u>		
3 SEX <u>M</u>		4 RACE <u>B</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>OCTOBER 11, 1986</u>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <u>4 33</u>		7b HOUR <u>4 33</u>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>U.M.H.</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY MD.</u>			
10 CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Maryland Hospital</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Baby</u>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <u>MD</u>					13c CITY OR TOWN <u>Balto.</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Deartriss Dempsey</u>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHLORAL - ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prenatal - Asphyxia / Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prenatal PLACENTAL Abruption</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&gt; 4 1/2 hrs.</u> <u>&gt; 4 1/2 hrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>10/11 1986</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/11 1986</u> , to <u>Oct. 11 1986</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Carlos ALAMA</u>					DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/11/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SARLOS ALAMA MD</u>					22e. ADDRESS <u>22 S. GREENE ST., Balto, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>			23b. DATE <u>10-16-86</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME <u>Anatomy Board</u>					ADDRESS <u>Balto., Md.</u>		25. DATE REC'D. BY REGISTRAR <u>OCT 22 1986</u>		
					26. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

1



00-20961

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN A HOUR AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A PERMIT TO BURY OR PERMIT TO TRANSFER SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84  
25M
 BP  
 DHMH - 17  
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28057	
1- STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT)			FIRST MARY			MIDDLE GERTRUDE			LAST DENBY		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 4/3/1930		6 AGE (IN YEARS) 56		7 IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7a. DATE KNOWN OF DEATH MATED 10-10-86	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				9a. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7b. DATE PRONOUNCED DEAD 10-10-86	
10 CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6511 O'Donnell Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		7d. HOUR 7AM	
13a. STATE Maryland				13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6511 O'Donnell St. (21224)	
14 FATHER'S NAME Louis				MIDDLE Krepner				15. MOTHER'S MAIDEN NAME Gertrude		LAST Hill	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218.26.5219				17 INFORMANT Susan Mullins 551 Langley Rd. Essex, Maryland 21221			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 10-10-86			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 10/11/1986		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory				23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE	
24 FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md. 21222						25a. DATE REC'D. BY REGISTRAR OCT 14 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

10/10/77

10/10/77

(1)

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0-221013

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
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 DHMH - 17  
 (VR A15 ME (5))

 1- FOR  
 STATE  
 REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 3 3 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Bessie A. DeSautel						10/ 22/ 19 86						M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Female	Cauc.	4 26 1906	80 YRS.			10/ 22/ 19 86						A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Mass.			U.S.A.						Baltimore City,					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			131 S. Conkling St.			Retired								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland						Highlandtown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			131 S. Conkling St. 21224		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Victor DeSautel			Theresa Abair			No			084-01-0107			Mrs. Beatrice Kuiken - 7006 Fait Av. 21224		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Cervical Injuries</u>														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost														
(b) _____														
DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
			? P.M. 10/ 22/ 19 86			subject fell down stairs								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			CITY OR TOWN			COUNTY STATE		
			stairway			131 S. Conkling St., Balto. City, Md.								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
TITLE (SPECIFY)														
ACTUAL SIGNATURE _____ M.D. Assistant MEDICAL EXAMINER													DATE SIGNED 10/23/86	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.													ADDRESS 111 Penn St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			COUNTY STATE		
Burial			10/25/86			Oak Lawn			Baltimore, Md.					
24. FUNERAL DIRECTOR NAME						25a. RECEIVED BY REGISTRAR						25b. REGISTRAR'S SIGNATURE		
Walter Dabrowski - 1005 Dundalk Ave. 21224						OCT 24 1986						J. B. Dabrowski		

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PAID FOR PAGE 5. FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items, 8a, 21a, 21b, 21c, 21d FOR 1- STATE 21e, 21f, 22a, G-621 REGISTRAR M. E. 11/22/86 DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 26859											
1. DECEASED NAME (TYPE OR PRINT) Sidney Devillasee				2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10/ 18/ 86				2b. HOUR 1:36 a m			
3 SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6- 4- 51		6. AGE (IN YEARS) LAST BIRTHDAY 35 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2824 Overland Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSING HOME		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY COUNTY MD BALTO.				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 3911 Frankford Ave 21206					
14. FATHER'S NAME FIRST MIDDLE LAST Leo H DeBillasee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Manigo				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. 212586863				17. INFORMANT ADDRESS Leo H. Devillasee 3911 Frankford Ave 21206							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 18 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject used drugs.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unk.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE unk.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE William M. Zane				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 10/18/86			
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-22-86		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS MD			
24. FUNERAL DIRECTOR MARCH FUNERAL HOMES						ADDRESS 1101 E. NORTH AVE		25a. DATE REC'D. BY REGISTRAR 10/20/86			
						25b. REGISTRAR'S SIGNATURE John Davidson					

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REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, LINE 1, PAGE 1. ITEMS 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE MEDICAL RECORDS, AND 5 TO THE FUNERAL DIRECTOR.  
**TO FUNERAL DIRECTOR:** PAGE 5 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 6 SHOULD BE FILED, WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 211 WESTBOSTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVING.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
ROBERT		(NMN)		DICKSON, JR.				2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Male		White		Aug 28 1931		55 YRS.		MONTHS		DAYS		HOURS		MIN.		10-9-86		19		3:30P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
New York				USA								Baltimore City											
11. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore				St. Agnes Hospital				Inspector				Westinghouse											
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Maryland				A A Co.				Glen Burnie				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				311 Shetland Lane 21061							
15. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
Robert				Mary																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT (Wife)				ADDRESS											
Yes				Korean				218.26.4580				Mrs. Rosalie J. Dickson				Same As #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				TITLE (SPECIFY)										DATE SIGNED									
<u>Margarita A. Korell</u>				M.D. Assistant MEDICAL EXAMINER										10-10-86									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Margarita A. Korell, M.D.				111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY				STATE			
Burial				Oct 13, 1986				Glen Haven Mem. Park				Glen Burnie				A A Co. Maryland							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Singleton Funeral Home				Glen Burnie, Maryland				OCT 14 1986															

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00-21427

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Betty</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 13, 1986</b>			2b. HOUR <b>10:48</b> <sup>A</sup> <sub>M</sub>							
3 SEX <b>female</b>		4 RACE <b>blk</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-3-61</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>25</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lynchburg, VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2427 lakeview 21216</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jesse Pannell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Moore</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>219-76-5639</b>		17. INFORMANT ADDRESS <b>Lucy Morton 1615 Warwick Ave. 21216</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marked cerebral edema with brainstem and</b> <b>xx cerebral necrosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <b>Widespread Bronchopneumonia</b> <b>Widespread Bronchopneumonia.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT PRESENT ON AUTOPSY, DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 22, 1986</b> to <b>October 13, 1986</b> , that <input checked="" type="checkbox"/> (we) saw the deceased alive on <b>October 13, 1986</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> not view the body after death.													
22b. SIGNATURE <b>Thomas H Ganey MD for Christopher Hogan</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/14/86</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Christopher Hogan, M.D.</b>						22e. ADDRESS <b>c/o Maryland General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-18-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eastview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>						
24. FUNERAL DIRECTOR NAME <b>Leroy O. Dyett &amp; Son 4600 Liberty Heights Ave</b>						25a. DATE REC'D. BY REGISTRAR <b>10/16/86</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and preliminarily filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move cards in papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other infirmity, the medical examiner must be notified at once.

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00-22255

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST					MONTH DAY YEAR					HOURS MIN.	
Virginia D. DiGirolamo					10-24-86					0345 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		white		MONTH DAY YEAR		75 YRS		MONTHS DAYS		HOURS MIN.	
01 27 1911											
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore W. Va.		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		North Charles General Hosp. 2724 N. Charles				unemp.		Homemaker			
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Md		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		113 E. Cross St. Balto. Md.					
14. FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)						
Frank Augustino Borrell					Vincenza Martino						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT (NAME AND ADDRESS)				
No					22048 5142		Balto. 1039 Marlau Dr. Staff Anthony A. DiGirolamo 21212				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) End Stage Chronic renal failure											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE					
22. I certify that (I (this hospital) attended the deceased from 10/10 to 10/24 1986 that (I (we) lost saw the deceased alive on 10/24 1986 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did not view the body after death.											
22b. SIGNATURE					DEGREE		22c. DATE SIGNED				
Borrell MD							10-24-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
Brenda J. Hopkins M.D.					North Charles General Hospital 2724 N. Charles St. Baltimore Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			10/27/1986		Meadowridge Mem. Pk		Elkridge, Howard Co. Md.				
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230					OCT 28 1986						

20% COTTON FIBER

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

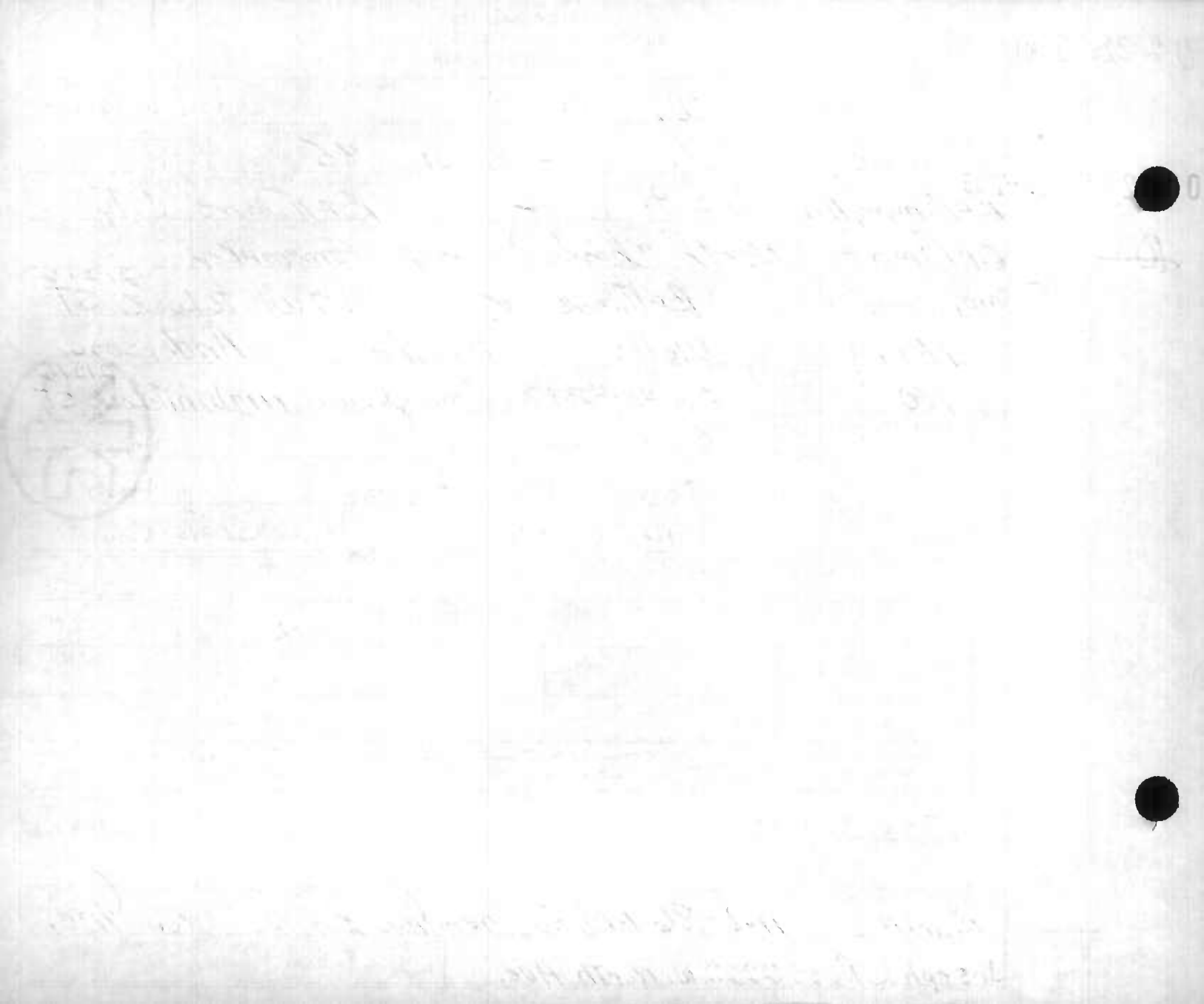
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS W. DIXON					2a. DATE OF DEATH MONTH DAY YEAR 10 / 31 / 86			2b. HOUR 6:40 P.M.			
3. SEX Female		4. RACE Col.		5. DATE OF BIRTH MONTH DAY YEAR 1 - 29 - 01		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
9. PLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) North Charles Gen. Hosp.		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		14. KIND OF BUSINESS OR INDUSTRY	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland		16. COUNTY Baltimore		17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 1117 White Lock St 21216		19. STREET ADDRESS / ZIP CODE 1117 White Lock St 21216		20. STREET ADDRESS / ZIP CODE 1117 White Lock St 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Wells		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Anderson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-40-4234		17. INFORMANT Mrs. Mary E. Wells		18. ADDRESS 1117 White Lock St 21216	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last: (b) <u>Cardiac Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mental Failure, Depress, Hypertensive Day</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>Hours</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b) PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-25-</u> 19 <u>86</u> , to <u>10-31-</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>10-31-</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Joseph L. Russ</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-31-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-6-86		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.					
24. FUNERAL DIRECTOR NAME Joseph L. Russ						25a. DATE REC'D. BY REGISTRAR NOV - 5 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



00-22601

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A BURIAL TRANSIT PERMIT MAY BE OBTAINED FROM THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28009

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Osborne B. DIXON SR.</b>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>XX 10-20 1986</b>			2b. HOUR M <b>10:20</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 14 09 77</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>77</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2229 Braddish Avenue</b>			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Relaxation Spec.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO.		
17. INFORMANT <b>Osborne Dixon Jr. 2021 McCullah St</b>			17. ADDRESS <b>21217</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Dennis F. Smyth</b>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER DATE SIGNED <b>10-23-86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>10-25-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBATUS MEM. PARK</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>		
24. FUNERAL DIRECTOR NAME <b>E.L. Phillips</b>				ADDRESS <b>F.H. 1721 N. Monroe St.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1986</b>		25b. REGISTRAR'S SIGNATURE	



0-21432

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Reginald

Dixon

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR  
10-11-86

2b. HOUR  
M  
12:49

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

1 30 49

6. AGE (IN YEARS LAST BIRTHDAY)

37 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

10-11-86

2d. HOUR

M  
12:49

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

1209 Bradford Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

N/A

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2251 E. Preston St 21213

14. FATHER'S NAME

Unk

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

Roszena

MIDDLE

Dixon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

218469295

17. INFORMANT

ADDRESS

Diane Dixon 924 N. Broadway 21205

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Intracerebellar Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) Hypertension

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Chronic Ethanolism

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED

10-11-86

EXAMINER'S NAME (TYPE OR PRINT)

Charles P. Kokes, M.D.

ADDRESS

111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, OR REMAINS (SPECIFY)

Burial

23b. DATE

10-18-86

23c. NAME OF CEMETERY OR CREMATORY

King Mem. Cemetery

23d. LOCATION

Randallstown MD

COUNTY STATE

24. FUNERAL DIRECTOR

NAME

March F/H

ADDRESS

1101 E. North Avenue

25a. DATE REC'D. BY REGISTRAR

OCT 16 1986

25b. REGISTRAR'S SIGNATURE

Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRESENT IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (1))

202 C-1101 B-12

CHERRYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of this certificate and file with the health department. If the death is due to natural causes, the death certificate should be filed with the health department within 24 hours after death. If the death is due to other causes, the death certificate should be filed with the health department within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH Margaret DODD			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 31, 1986			2b. HOUR 7:02 PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 30 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY Lee Uniform							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY BALTIMORE		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 6526 Riverview Ave. 21222			
14. FATHER'S NAME FIRST MIDDLE LAST Seraphin Seubenth				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-28-5076		17. INFORMANT ADDRESS Gloria M. Winkelman 8147 Kavanagh Rd. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/27, 1986, to 10/31, 1986, that (I) (we) lost saw the deceased alive on 10/31/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D. Hoopes, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/31/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DWIGHT HOOPER, M.D.				22e. ADDRESS GOOD SAMARITAN HOSPITAL (BALTO.)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-5-86		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				ADDRESS 6224 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR NOV 5 1986	
				25b. REGISTRAR'S SIGNATURE Air Jordan Prince			

100-22881

XX

XX



11-7-71

100-22881



0-20240

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28007

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JUANITA				DODD	10-1-86				10:30 PM
3. SEX	F	4. RACE	B	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)				
				MONTH DAY YEAR 2 13 1927	59 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.				Baltimore city MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Lutheran Hospital								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland		Baltimore			21217 Key Circle Nursing Home				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
Warren		Johnson		Viola		Lightfoot		16b. SOCIAL SECURITY NO.	
								217-22-4885	
								17. INFORMANT ADDRESS	
								Cynthia Graham 2401 Lakeview Ave. 21217	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic shock.</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Decubiti ulcers.</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital), attended the deceased from <u>8-13-</u> 19 <u>86</u> , to <u>10-1</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>10-1</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Bich T Duong</u>		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10-1-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG		22e. ADDRESS LUTHERAN HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		10-8-86		Mount Zion Cemetery		Baltimore Maryland			
24. FUNERAL DIRECTOR NAME		25a. DATE RECD. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Bailey Funeral Home 1348 N. Calhoun St. 21217		OCT 07 1986				<u>[Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

04505-0



0-21712

DIVISION OF VITAL RECORDS, 2D1 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should remain with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
THOMAS W DODSON, Sr.						October 20, 1986			11:16PM			
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Male		White		04 15 15		71 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania			USA						BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE			VAMC, LOCH RAVEN, BALTIMORE, MD						Constr. Worker		Dozer	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland			--		Baltimore				816 West 37th Street 21211			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Charles Dodson			(unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
Yes			WW II		194-01-6726 Catherine B. Dodson 816 W. 37th Street 21211							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADENOCARCINOMA OF THE LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <u>Chronic Obstructive Pulmonary Disease</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 5, 19 86</u> , to <u>October 20, 19 86</u> , that <u>XX</u> (we) last saw the deceased alive on <u>October 20, 19 86</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) (did <u>XXXX</u> ) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
<u>James A. Dele, Md.</u>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			<u>10/20/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			10/23/86		Crest Lawn Gardens			Baltimore Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
A. Alan Seitz, Jr. 3818 Roland Ave. 21211						OCT 22 1986		<u>James Dodson</u>				

BP

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*[Faint, mostly illegible text, possibly a memorandum or report, covering the majority of the page.]*



00-20308

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28007

FOR  
1- STATE  
REGISTRAR

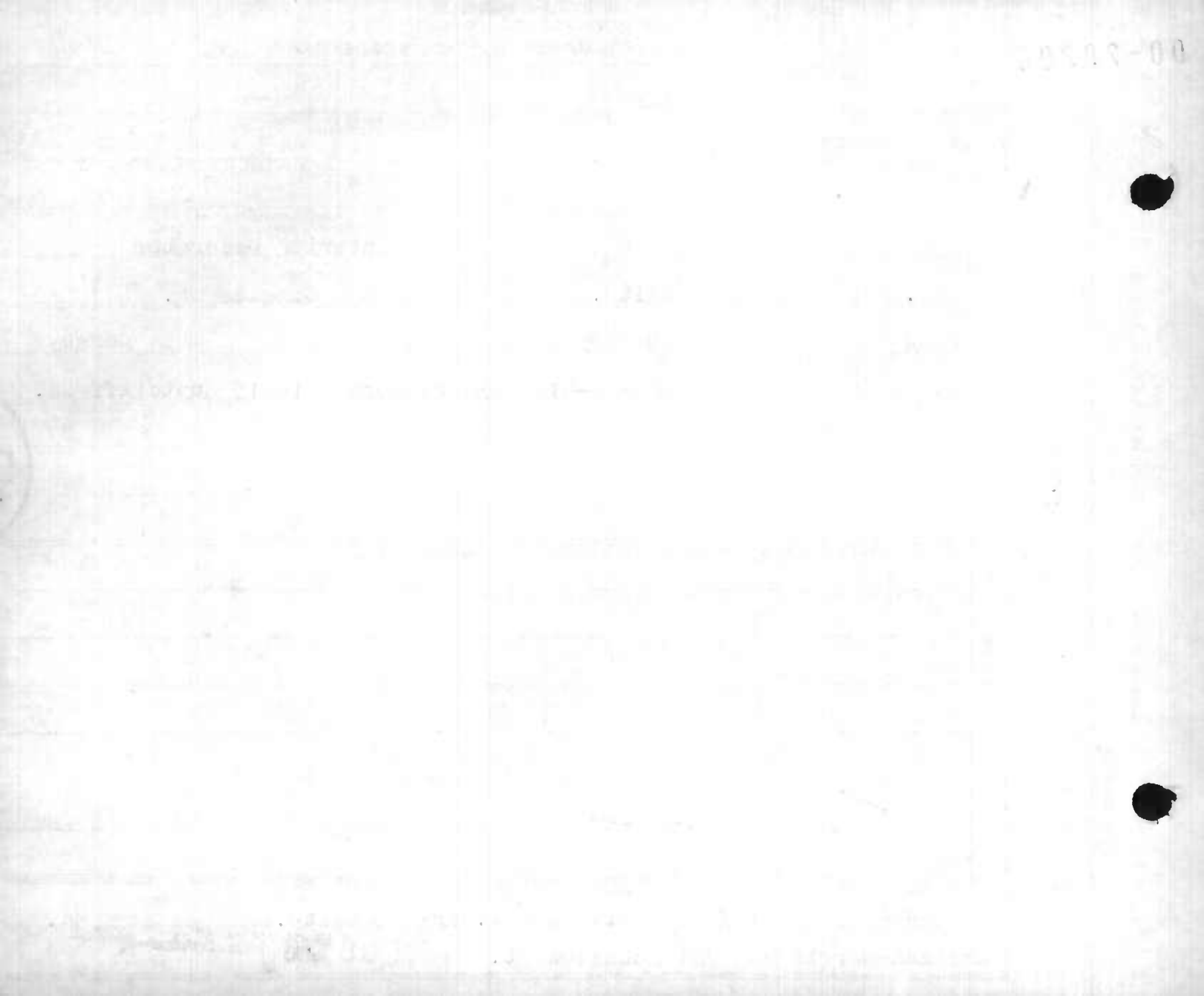
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
John Henry Dorsey								10 6 19 86								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	5 14 27		59 YRS.						10 6 19 86						1:30P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA														Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		University Hospital (STU)		Interior Decorator													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		456 Cummins Ct.		21201							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Leon Dorsey		Mae Dorsey															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		220-20-6198		Albert Dorsey		10913 Huntcliff Rd.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART 1 DEATH CAUSED BY:																	
IMMEDIATE CAUSE (a) Cranio cerebral trauma with complications																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		8:30 P.M. 9 19 86		subject fell down steps													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
		house		450 Waddy Court		Baltimore				MD							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
William M. Zane, M.D.		Assistant		10/7/86													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
William M. Zane, M.D.		111 Penn St. Balto.MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		10/10/86		Eastview Mem. Park		Balto.						Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Chatman-Harris FH 1701 McCulloh St.		OCT 08 1986															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN SPACE IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified of the event.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 86 28071									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Palestine		Downes						10-12-86		1:50 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
F		B		2 21 21		65 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore, City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Good Samaritan									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21213	
Maryland				Baltimore				1627 East Lafayette Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
James Clarence Stone		Wilhelmena									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
no		213145156		Harry Downes 1627 East Lafayette Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST										5 MIN	
DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE										2 YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS										15 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METABOLIC ACIDOSIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JULY 11 1986 to OCTOBER 12 1986 that (I) (we) last saw the deceased alive on OCTOBER 11 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
JUN R. RESAR M.D.		MD						10/12/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
JUN R. RESAR M.D.		JOHNS HOPKINS HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL		10-17-86		KING MEMORIAL		Randallstown MD STATE					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MARCH F/H 1101 E. NORTH AVENUE						OCT 16 1986					

00-51183



00-22453

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8028012	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) VERNON L DRANBAUER				2a. DATE OF DEATH MONTH DAY YEAR 10 25 86				2b. HOUR 10:30 PM			
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 02 07		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY KOPPERS CO.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY BALTIMORE CITY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 604 W 34TH ST BALTO. 21211	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Rudolph Dranbauer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Harwood							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1924-1928 212-01-8284		17. INFORMANT ADDRESS David Dranbauer 1671 Langford Rd. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CHRONIC OBSTRUCTIVE PULMONARY DISEASE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 9/23, 1986, to 10/25, 1986, that (I) (we) lost saw the deceased alive on 10/25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Pankaj Talwar				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/25/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PANKAJ TALWAR				22e. ADDRESS GOOD SAMARITAN HOSPITAL.							
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 10-29-86		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co Md.			
24. FUNERAL DIRECTOR NAME Burge-Henss FH 3631 Falls Rd. 21211						25a. DATE REC'D. BY REGISTRAR OCT 29 1986		25b. REGISTRAR'S SIGNATURE			

SIREH

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00-20246

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH				MONTH		DAY		YEAR		21. HOUR									
JOHN E. DRAPER								10-3-86				19						M									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		70. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		21. HOUR							
M		W		8-13-1957		29 YRS.						10-4-86				19		2:30P									
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				71. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH															
MARYLAND				U.S.A.				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore City MD.															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore				610 Quail Street				MEAT CUTTER				MARKET															
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS											
MD.								BALTO.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				610 S. QUAIL ST. 21224											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
JOSEPH V. DRAPER				MARY I. McCUBBIN				No				216-74-2865				Mrs. Mary I. Draper - 624 N. Highland Ave 21205											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																											
PART I DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen</u>																											
DUE TO, OR AS A CONSEQUENCE OF																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																											
(b) _____																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c) _____																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?															
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																			
				P.M. 10-3-1986				self/inflicted																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY				STATE							
				bedroom				610 quail Street				Baltimore, Maryland															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED																			
				M.D. Deputy Chief				10-5-86																			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																							
Ann M. Dixon, M.D.				111 Penn Street																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				CITY OR TOWN				COUNTY				STATE			
CREMATION				10-8-86				GREENMOUNT CREMATORY				BALTO.				MD.											
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Gentle Miller				2334 Jefferson St.				OCT 07 1986																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 100-20246. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 B4  
25MBP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 0 1 4  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Gerard A. Droll</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 2 86</b>			2b. HOUR <b>6:15 AM</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 22 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY - BALTIMORE, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANCIS COTT KEY Med. Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISPATCHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL CO.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>902 N. LUZERNE AVE. 21205</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANCIS DROLL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LEONA WILHELM</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-01-5167</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy Martin - 2020 Harman Ave. 21230</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INFECTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-10-86</b> to <b>10-2-86</b> , that (I) (we) last saw the deceased alive on <b>10-2-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Grace A. Corotis MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10-2-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Grace A. Corotis</b>				22e. ADDRESS <b>FSKMC - 4940 Eastern Ave, Balt 21224</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-7-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR MEMORIAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BEL AIR, MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Smith, Ralph - 7527 Harford Rd.</b>				ADDRESS <b>7527 Harford Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 07 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, correct, complete, and sign page 4 and 5, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION





00-20156

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JACQUELYN L. DUDZAK</b>		2a. DATE OF DEATH MONTH <b>10</b> DAY <b>2</b> YEAR <b>86</b>		2b. HOUR <b>4:10 A</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>5</b> YEAR <b>1944</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Defense</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Dudzak</b> LAST <b>Dudzak</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ruth</b> MIDDLE <b>Watson</b> LAST <b>Watson</b>		16. STREET ADDRESS / ZIP CODE <b>6464 Colonial Knoll 21061</b>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		17b. SOCIAL SECURITY NO. <b>212-42-2250</b>		17. INFORMANT <b>Ruth A. Dudzak</b> ADDRESS <b>413 Harwood Road Catonsville, MD. 21228</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic adenocarcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 1</b> , 19 <b>86</b> , to <b>OCT 2</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>OCT 2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Harold Blumenthal, M.D.</b>		DEGREE		22c. DATE SIGNED <b>OCT 2, 1986</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold Blumenthal MD</b>		22e. ADDRESS <b>3001 S. Hanover St Baltimore</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/4/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Dorsey</b>		COUNTY <b>Maryland</b>		STATE	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 06 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
1630 Edmondson Avenue, Catonsville, MD. 21228					

00-50120

THE POWER OF THE PEOPLE

8 OF 11

6

Amendment

00-21995

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23010

1. DECEASED NAME (TYPE OR PRINT) Nancy J. Duffy			2a. DATE OF DEATH MONTH DAY YEAR 10 14 86			2b. HOUR 1028 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 04 61		6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Medical Systems				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk-Drug Store		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Norman H. Bowen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? Polk			13e. STREET ADDRESS / ZIP CODE Pasadena, Md. 339 Cambridge Rd. #21122			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-80-3002		17. INFORMANT 339 Cambridge Rd. - Pasadena, Md. Michael W. R. Duffy		ADDRESS #21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lack of cortical or brainstem function (brain death) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis with multiple complications DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48hr 1wk									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION 8-29-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Multiple brain lesions				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-27, 19 86, to 10-14, 19 86, that (I) (we) lost saw the deceased alive on 10-14, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. Marshall		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 10/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Marshall				22e. ADDRESS Univ. of Md. Hospital 225 Greene Street.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 17, 1986		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME G. Truman Satwab				3510 Frederick Ave. ADDRESS #21129		25a. DATE REC'D. BY REGISTRAR OCT 23 1986		25b. REGISTRAR'S SIGNATURE	

BP



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28078

1. DECEASED NAME (TYPE OR PRINT) Brian Timothy DUFOUR			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 2, 1986			2b. HOUR 11:35 AM	
1. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1986		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U.s. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -----	
12b. KIND OF BUSINESS OR INDUSTRY -----							

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 10800 PFEFFERS Rd 21021	
14. FATHER'S NAME FIRST MIDDLE LAST Tomothy C. Dufour		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bonnie Coleman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ---		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Mr. Timothy Dufour 10800 Pfeffers Rd. Bradshaw, Md. 21021	

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

## DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

## (b) Sepsis

## DUE TO, OR AS A CONSEQUENCE OF

(c) Necrotizing Enterocolitis

## APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 mins.

4 days

8 days

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/26, 1986, to 10/2, 1986, that (I) (we) last saw the deceased alive on 10/2, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jungjoo ELICA KANG MD				DEGREE MD		22c. DATE SIGNED 10/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jungjoo ELICA KANG MD				22e. ADDRESS 600 N. WOLFE ST. BALTO., MD JOHNS HOPKINS HOSPITAL 21205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-4-1986		23c. NAME OF CEMETERY OR CREMATORY Forest Baptist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Upperco Baltimore Md.	
24. FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087				25a. DATE REC'D BY REGISTRAR OCT 06 1986		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit receipt. Then please remove carbon pages. Pages 1 and 2 should be filed with the funeral director within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed in the coroner's office.

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00-2164

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28079

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
ESTHER A. DUKE			OCTOBER 19, 1986			7:10 P M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR		
Female	White	June 3, 1897 <sup>AR</sup>	89			MONTHS DAYS HOURS MIN.		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
Balto., Md.	U.S.A.	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	THE JOHNS HOPKINS HOSPITAL			Ret. Munitions Worker-Govt.			U.S.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b INSIDE CITY LIMITS?			13c STREET ADDRESS / ZIP CODE		
Md. Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12 N. Milton Ave.-21224		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
Frederick Duke			Bertha Schmizer					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			ADDRESS		
No			220-20-7007A			Md. 21224		
			Edward J. Duke-227 N. Lakewood Ave.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:								APPROX. INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>								10 minutes
DUE TO, OR AS A CONSEQUENCE OF								
(b) <u>Chronic obstructive pulmonary disease</u>								YEARS
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 110								
<u>Ventilator dependency</u>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
8/5/86			Right hip fracture			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			P.M. 7 23 1986			Fall at home		
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			home			12 N. Milton Ave., Balto., Md. 21224		
22a I certify that (I) (this hospital) attended the deceased from <u>7/28/86</u> 19 <u>86</u> , to <u>10/1/86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/1/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE			DEGREE <u>no</u>			22c DATE SIGNED		
<u>Clay A. Butler MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			10/9/86		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS					
Clay A. Butler MD			600 N. Wolfe St. Balto. MD 21205					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial			10/22/86		Baltimore Cemetery		Baltimore, Maryland	
24 FUNERAL DIRECTOR NAME			24b ADDRESS			24c DATE REC'D. BY REGISTRAR		
John A. Moran, Inc. Funeral Home			3000 E. Baltimore St., Balto., Md. 21224			OCT 21 1986		
			25b REGISTRAR'S SIGNATURE					

RELEASED BY MEDICAL EXAMINER ON APPROVAL PER DR. KOKUSZMR. PURV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial permit. The permit is removed from this page. Pages 1 and 2 are to be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 2 is marked or item 18 shows any injury, the medical examiner must be notified.

BP

FILED  
MAY 19 1964  
FBI - NEW YORK

REC-11

2807

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00-22291

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8080

1. DECEASED NAME (TYPE OR PRINT) <b>James M. Dunaway</b>			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR <b>10-10-1986</b>			2b. HOUR M <b>3:03 p.m.</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 16 22</b>	6. AGE (IN YEARS, LAST BIRTHDAY) <b>63 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10-10-1986</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>417 S. Collington Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(Soc. Security)</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret</b>		17. INFORMANT ADDRESS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Ethanolism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER					DATE SIGNED <b>10-11-86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles P. Kokes, M.D.</b>		ADDRESS <b>111 Penn St., Baltimore, Md. 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>10-21-86</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT RECORD. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25M

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(VR A15 ME (5))



00-20170

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8028031

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY Elizabeth DUNCAN</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>1</b> YEAR <b>86</b>			2b. HOUR M				
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>5</b> YEAR <b>20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.				
10. CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2746 Ellicott Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House wife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>A.</b> LAST <b>Combash</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Gladys</b> MIDDLE <b>T</b> LAST <b>Too good</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>211-18-0251</b>		17. INFORMANT <b>WM A. DUNCAN Sr.</b>				ADDRESS <b>2746 Ellicott</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**Severe rheumatoid arthritis**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____ that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Scrimin</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-3-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUGETA SAPPARI, MD</b>		22e. ADDRESS <b>1910-14 W. Pratt St., Baltimore, MD</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-6-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest</b>		23d. LOCATION CITY OR TOWN <b>OWINGS MILLS</b> COUNTY <b>MD</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Wm. C. Brown</b> ADDRESS <b>1206 W. North Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 07 1986</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

99

BP

10-50152

CLASSIFIED  
MEXICO  
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00-22435

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 8 0 8 2

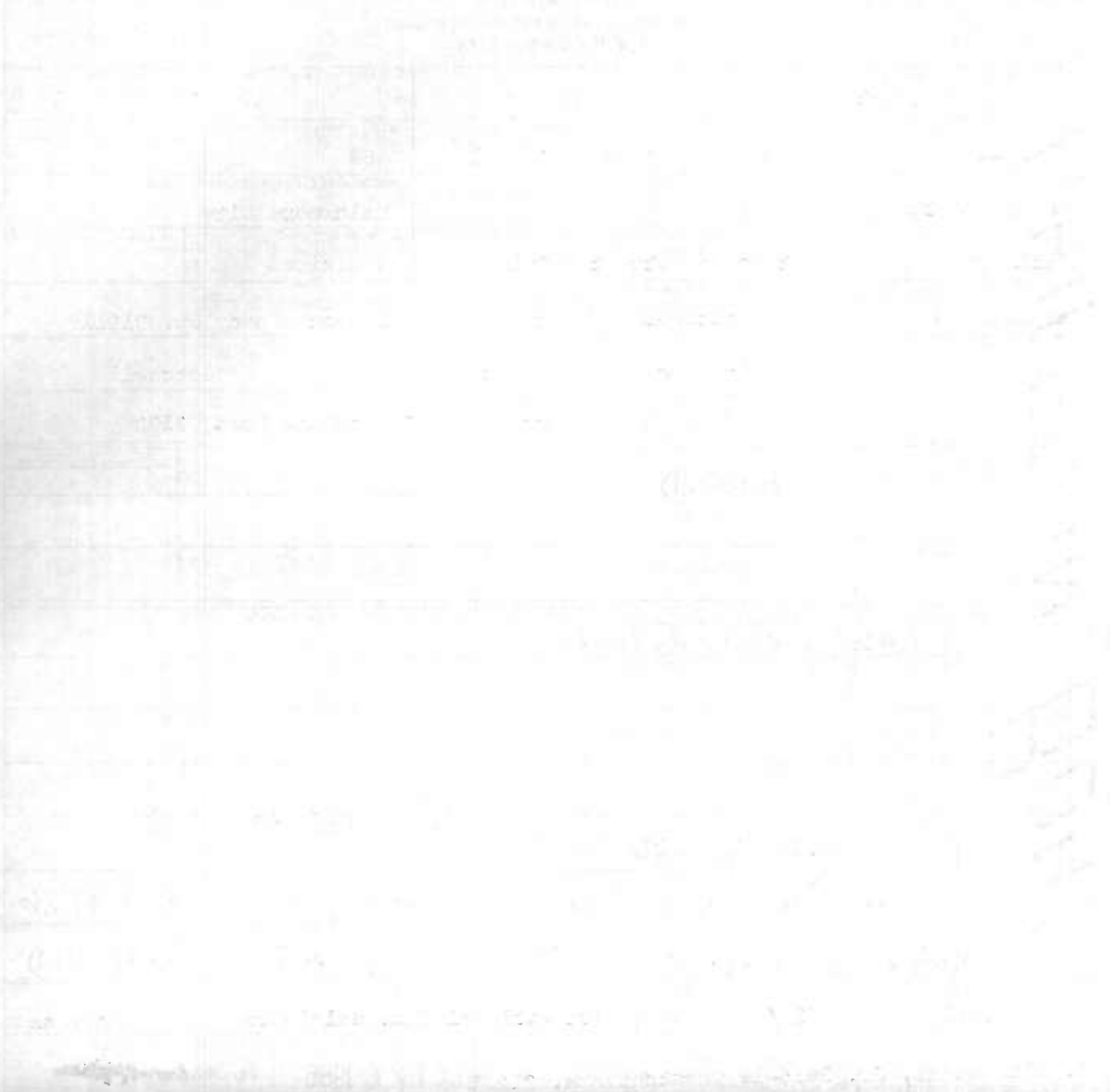
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Marietta		Dyer		10		24		86	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR 04 28 17		69		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Massachusetts		USA				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		1 West Conway Street 21201				Retired			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST Raymond A. Hitchcock				FIRST MIDDLE LAST Ruth E. Getchell		1 West Conway St. 21211			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO				015-14-4153		Harry Dyer 620 Markham Road 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HASCD</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Large Vessel Arteritis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>75</u> , to <u>Oct 28</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Sheldon Goldberger MD</u>			DEGREE MD			22c. DATE SIGNED Oct 27 '86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Sheldon Goldberger</u>			22e. ADDRESS <u>711 W 40th Street Balto MD</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			10/28/86		Baltimore National Cem.		Baltimore Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 21211					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
					OCT 28 1986		<u>Sheldon Goldberger</u>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



(11.000)





00-21470

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28083

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN COREAN DYSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-11-86</b>			2b. HOUR M <b>10</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>05-15-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO., MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2200 KOKO LANE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>2200 KOKO LANE 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLARA SMITH</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>LAROE DYSON 2200 KOKO LANE</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardiovascular disease</b>	
		DUE TO, OR AS A CONSEQUENCE OF (c)	
		4-6 mon	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) ( <del>she</del> ) attended the deceased from <b>Nov</b> 19 <b>83</b> to <b>Oct 11</b> 19 <b>86</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>September 22</b> 19 <b>86</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
22b. SIGNATURE <b>Sheila G. Walker</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-13-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sheila Walker MD</b>				22e. ADDRESS <b>3502 W. Roger Ave, Baltimore Md 21218</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-15-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LA UREL, MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>BROWN/THOMPSON F.H. 1913 W. BALTIMORE ST.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1986</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical certificate must be certified by a physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



0-22792

Items, #1, 14, G-621, by both STATE OF MARYLAND  
 FOR parents, / 11/17/86 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 1- STATE REGISTRAR Gbj./ per. D.L./M. CERTIFICATE OF DEATH  
 REG. NO. 2800

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Tyeisha Lue Etta Morris		2a. DATE OF DEATH MONTH DAY YEAR 10 24 86		2b. HOUR 1200 <sup>M</sup>	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 10 24 86		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 34	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY —
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1353 Carroll St. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Eaddy, Jr.		15. MOTHER'S MAIDEN NAME MIDDLE LAST (error) Lue Etta Morris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Birth asphyxia &amp; lung hypoplasia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple congenital anomalies</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Intrauterine growth retardation, prematurity</u>					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>24 Oct</u> , 19 <u>86</u> , to <u>24 Oct</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>24 Oct</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE James M. Chamberlain		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James M. Chamberlain		22e. ADDRESS Pediatric Housestaff Office 22 So. Greene St. Baltimore 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-28-86		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.			
25a. DATE REC'D. BY REGISTRAR OCT 31 1986		25b. REGISTRAR'S SIGNATURE Julia Benson-Bader			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OCT 3 1 1950

00-21550

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28085

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William H. Eady</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>10 17 86</i>		2b. HOUR MIN. <i>335 P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 2 02</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Norfolk, Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>84</i>	
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secor</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD	
13a. STATE <i>Md</i>		13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Balto</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>unk</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>unk</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bathlehem Steel</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>218-10-6493</i>		17. INFORMANT ADDRESS <i>Mrs. Helen Bodley 2328 McCulloh St. 21217</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>adult respiratory distress syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 13, 1986</i> to <i>Oct 17, 1986</i> , that (I) (we) last saw the deceased alive on <i>Oct 17, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Warshawsky</i>		DEGREE <i>Resident</i>		22c. DATE SIGNED <i>10/17/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul Warshawsky</i>		22e. ADDRESS <i>Bon Secor Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>10-22-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>James A. Morton &amp; Sons 1701 Laurens St.</i>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Oct 20 1986</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.



*[Faint, mostly illegible handwritten text and markings on lined paper. The text is written in cursive and spans across the page. Some words are difficult to decipher due to the fading and the style of the handwriting. There are also some small marks and symbols scattered throughout the text.]*

00-21473

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 6 2 8 0 0 0		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RONALD		F.		EAGAN				10 15 86		11:05 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
Male		White		Aug 17, 1950		36		YRS			
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE CITY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.			
BALTIMORE		UNION MEMORIAL HOSPITAL		Lock Smith		State of MD.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		Baltimore				501 N. Curley Street 21205			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Albert Edward Eagan				Helen Dutton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				220-52-4586		Margaret A Eagan 501 N. Curley St Baltimore 21205					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>CO<sub>2</sub> narcosis / respiratory arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple sclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>aspiration pneumonia</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>S/P ileal loop, cystectomy, prostatectomy, &amp; appendectomy</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
10/9/86		recurrent ureteritis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/9/86</u> 19 <u>86</u> , to <u>10/15</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Robert Hsiao M.D.								October 15, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
DR. ROBERT HSIAO M.D.				201 W. UNIVERSITY PARKWAY							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		10/18/86		Most Holy Redeemer Cem		Baltimore, MD.					
24. FUNERAL DIRECTOR NAME				24b. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
The Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, Maryland 21206				OCT 17 1986							

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00-21900

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 3 1

1. FOR  
STATE  
REGISTRAR

Charles Eakers

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES EAKERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 / 19 / 86</b>		2b. HOUR <b>12<sup>40</sup> AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 3 02</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Singer Co.</b>		13a. STREET ADDRESS / ZIP CODE <b>APT. 1120 301 McMECHEN ST 21217</b>				
13b. STATE <b>MARYLAND</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD H. EAKERS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AGNES STEGEMAN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>—</b>		16b. SOCIAL SECURITY NO. <b>212035207</b>		17. INFORMANT ADDRESS <b>Flora Femling (sister) same address</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VENTRICULAR Arrhythmias</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PERFORATED duodenal Ulcer</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION <b>9/12/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 9</b> , 19 <b>86</b> , to <b>Oct 19</b> , 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>Oct 19</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dan Wenberg</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/19/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAN WENBERG</b>		22e. ADDRESS <b>3001 S. Hanover ST</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/21/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS CITY OR TOWN STATE <b>Schmunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>			
25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP

00-51000



0-20096

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Claire H. armonie Ebel			2a. DATE OF DEATH MONTH DAY YEAR 10 4 86		2b. HOUR 0012 M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 2 4 20	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework		12b. KIND OF BUSINESS OR INDUSTRY At Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Fitchugh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nicholosa Noel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 062-16-6373		17. INFORMANT ADDRESS John C. Ebel 406 Edgewood Road 21040	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest-Disseminated Intravascular COAGULOPATHY DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a					
19a. DATE OF OPERATION 10/3/86; 10/4/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Morbid Obesity; Colostomy Revision		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 9/28, 19 86, to 10/4, 19 86, that (I) (we) last saw the deceased alive on 10/4/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ronald E. Hempling MD				22c. DATE SIGNED 10/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald E. Hempling, M.D.				22e. ADDRESS Union Memorial Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-4-86		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial	
23d. LOCATION (CITY OR TOWN) Westview, Balto. Co., Md.		23e. STATE Md.			
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. 901 S. Conkling St.				25. DATE REC'D. BY REGISTRAR OCT 06 1986	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 28089  
7a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 10-21 1986  
7b. HOUR M 5:28 P.M.

1- FOR STATE REGISTRAR  
1. DECEASED NAME FIRST MIDDLE LAST Robert S. Eby Sr.  
3 SEX Male 4 RACE White 5. DATE OF BIRTH MONTH DAY YEAR 4 21 28 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. 7c. DATE PRONOUNCED DEAD 10-21 1986

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.  
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1924 Fleet Street - 2nd floor 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Photo. 12b. KIND OF BUSINESS OR INDUSTRY Photo.

13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Ellicott City 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 8618 Beechnut Court, 21043

14. FATHER'S NAME FIRST MIDDLE LAST Frances Eby 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Tessmer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. 215-24-8652 17. INFORMANT ADDRESS Joye Eby 8618 Beechnut Court Ellicott City, Md. 21043

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Hanging  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 10-21 1986 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged himself  
21d. INJURY OCCURRED WHILE ☒ NOT WHILE ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) photo lab 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1924 Fleet St.-2nd fl., Balto., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☒ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-22-86

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Oct. 24, 1986 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.

24. FUNERAL DIRECTOR Harry H. Witzke & Family, 4112 Columbia Road, F Uneral Home, Inc., E Ellicott City, MD. 25a. DATE REC'D. BY REGISTRAR OCT 24 1986 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THE CERTIFICATE MUST BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

2025 COLLEGE HALL

St. 2.

White A 21 28 29

U.S. Maryland

Photo. Photo.

2000 Washington Ave. and Ellicott City x 2818 Beechmont Court, 21043

Frances Hwy Hwy Hwy Tanager

Yes 1/23/66 212-24-0031 Joyce Hwy 2818 Beechmont Court Ellicott City, Md. 21043

Oct. 23, 1966 Garrison Hotel Baltimore  
Harry H. White & Family 4112 Columbia Road  
F. H. White, Inc., Ellicott City, Md.

00-21882

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8028090	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Luvenia</u> MIDDLE <u>A.</u> LAST <u>Edwards</u> <u>LUVENIA A. EDWARDS</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>10</u> <u>10</u> <u>86</u>		2b. HOUR <u>2:25</u> PM	
3. SEX <u>female</u>	4. RACE <u>blk.</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>7-27-12</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Accomac Co., Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.		10. CITY OR TOWN OF DEATH <u>Balto.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Bon Securus Hosp.</u>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <u>Md.</u>		12b. COUNTY <u>Balto.</u>		12c. CITY OR TOWN <u>Balto.</u>	
12d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12e. STREET ADDRESS / ZIP CODE <u>4130 Fairfax Rd.</u>		12f. ZIP CODE <u>21216</u>	
13. FATHER'S NAME FIRST MIDDLE LAST <u>John Thomas Wise</u>		14. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Alice Walker</u>		15. INFORMANT ADDRESS <u>Susie Stackhouse 3917 Duval Ave.</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>217-30-4223</u>		17. INFORMANT ADDRESS <u>Susie Stackhouse 3917 Duval Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced gastric carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>2:00</u> <u>10</u> <u>10</u> <u>86</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/26/85</u> to <u>10/10/86</u> , that (I) (we) lost saw the deceased alive on <u>10/10/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Nisha Soprey</u>		22c. DATE SIGNED <u>10/11/86</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NISHA SOPREY</u>	
22e. ADDRESS <u>2300 Garrison Blvd Balto Md 21216</u>		22f. DATE SIGNED <u>10/11/86</u>		22g. REGISTRAR'S SIGNATURE <u>Heroy O Dyett</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-15-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto., Md.</u>		23e. DATE REC'D. BY REGISTRAR <u>OCT 15 1986</u>		23f. REGISTRAR'S SIGNATURE <u>Heroy O Dyett</u>	

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

28091

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			KNOWN ESTI MATED <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR							
Mamie			E.			Edwards			10/23/ 1986			M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		Black		2 2 18		68 YRS.		MONTHS DAYS		HOURS MIN		10/23/ 1986		1:24 P M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
North Carolina				U.S.A.								Baltimore City, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore				Johns Hopkins Hospital				N/A				Domestic							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2700 Beryl Avenue 21205			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST				FIRST MIDDLE LAST															
Thomas				Askew				Fannie Hoggard											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
Unknown				217-26-2651				Jacqueline Carter 2700 Beryl Avenue											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE _____ M.D. Assistant										DATE SIGNED 10/24/86									
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL				10/28/86		Edward's Cemetery				Ahoski, N.C.									
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
MARCH Funeral Homes 1101 East North Avenue										OCT 27 1986									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM M-3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST <b>EDMUND</b> MIDDLE <b>ALFRED</b> LAST <b>EHATT SR.</b> <b>EDMUND ALFRED EHATT</b>		2a. DATE OF DEATH MONTH <b>10</b> DAY <b>27</b> YEAR <b>86</b> <b>10 27 86</b>		2b. HOUR <b>1255A</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>October</b> DAY <b>11</b> YEAR <b>1906</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>80</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Policeman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		13a. STREET ADDRESS / ZIP CODE <b>109 Garden Ridge Road 21228</b>	
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Ehatt</b> LAST <b>Schneider</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b>Schneider</b> LAST <b>Schneider</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>216-40-2189</b>		17. INFORMANT <b>Mrs. Isabell Ehatt</b>		ADDRESS <b>Same as # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Peripheral Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>CHF, Cirrhosis liver, COPD, Aortic &amp; Mitral Valve Stenosis, dehydration.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> , 19 <b>86</b> , to <b>10/27</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>10/27</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. Blake Kutsche M.D.</b>		DEGREE		22c. DATE SIGNED <b>10/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. BLAKE KUTCHE</b>		22e. ADDRESS <b>900 CATON AVE BALTIMORE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/30/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Woodlawn</b>		COUNTY <b>Maryland</b>		STATE	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke</b>		25a. DATE RECEIVED BY REGISTRAR <b>Oct 27 1986</b>		25b. REGISTRAR'S SIGNATURE	
1630 Edmondson Avenue, Catonsville, MD. 21228					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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*[Faint, illegible text and markings are visible across the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 7 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louis J. Eli</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 28 86</b>			2b. HOUR <b>3:42 P.M.</b>				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 5 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Chicago</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mary Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARNIVAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Carnival</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>819 LIGHT ST. 21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Eli</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY BUTCH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-20-0537</b>		17. INFORMANT ADDRESS <b>Danny Eli 819 LIGHT ST 21230</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adult Respiratory Distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pulmonary Emboli Transitional Cell Carcinoma of the Bladder</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <b>10/8</b> 19 <b>86</b> to <b>10/28</b> 19 <b>86</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>10/28</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <b>W. Todd M.D.</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10/29/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nervis W. Todd M.D.</b>			22e. ADDRESS <b>301 St. Paul Place Mary Hospital Balt.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10-31-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Frank L. Dellapane</b>			ADDRESS <b>322 S. High St</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 03 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John L. Dellapane</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other conditions, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 28094	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) PAULINE ENGEL ELIAS					2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 29, 1986			2b. HOUR 2:50A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 15, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE APT. 108 7313 PARK HTS. AVE., 21208			
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD EVERETT ENGEL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE WEIL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 218-05-4286		17. INFORMANT MR. HORACE J. ELIAS APT. 108 7313 PARK HTS. AVE. BALTO., MD 21208							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>PULMONARY AND RENAL FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Since 9/27/86</u> <u>Since 9/10/86 / 10/13/86</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION 9/5/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL INTESTINAL OBSTRUCTION				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> , 19 <u>86</u> , to <u>10/29</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>NAJI BADDJOURA</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/29/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NAJI BADDJOURA				22e. ADDRESS JHH							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 30, 1986		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR NOV 5 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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00-22134

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 2 8 0 9 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Viola — ELLENBERG</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10 15 86</b>		2b. HOUR <b>12 55 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 6 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Md.</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deacon Hospital + Med. cal center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Custodian</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Office Bldgs</b>
13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown — Grif Ath</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown —</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NA NA</b>		16b. SOCIAL SECURITY NO. <b>220-14-2870</b>		17. INFORMANT ADDRESS <b>Ray Ominsky 2909 Fallsta AA Rd. Balto, Md 21209</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis 2° gangrene, left foot</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Removal 2° recurrent CVA's</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 86</b> , to <b>15 Oct 86</b> , that (I) (we) last saw the deceased alive on <b>15 Oct 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>J. J. Reed M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/15/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. J. REED MD.</b>		22e. ADDRESS <b>611 S. CHAS. ST. BALTO. MD. 21202</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct-18-1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>AMICALO</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Atlanta Dawson Georgia</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>MARK A. CHOJNACKI Balto, Md. 21231</b>		
25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1986</b>		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28070

1. DECEASED NAME (TYPE OR PRINT) <b>Charles James Elliott Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-19-86</b>			2b. HOUR <b>7:05 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 3 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City Balto.</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Longshoreman</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>58 East Heath Street 21230</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William ----- Elliott</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary ----- Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WFW.11 214182304</b>		17. INFORMANT <b>Balto. Md. 58 E. Heath St. Mrs. Thelma M. Elliott</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra abdominal adenocarcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>10-19-86</b> to <b>10-19-86</b> , that (I) (we) last saw the deceased alive on <b>10-19-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Malinda H. White</b>			DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10-19-86</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Malinda H. White</b>			22e. ADDRESS <b>3001 South Hanover ST, Baltimore, md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/23/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cent.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. A.A. Co. Maryland</b>			
24. FUNERAL DIRECTOR <b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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OCT 20 1986



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00-22101

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28097  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Diane Elmore		2a. DATE OF DEATH MONTH DAY YEAR 10 / 23 / 86		2b. HOUR 7:45 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 08 25 1956		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD
9. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE COUNTY Maryland Somerset Pr. Anne md		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 415 Annick Ave 21853	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Elmore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regal Elmore Stevenson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A	17. INFORMANT ADDRESS Yvonne E. Moore Apt #11 Pr. Anne md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest; Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } Stg II B Stg CMI Ca CX - metastasis DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/16, 19 86, to 10/23, 19 86, that (I) (we) last saw the deceased alive on 10/23, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) know the body after death.				
22b. SIGNATURE Thomas O'Brien	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/23/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas O'Brien	22e. ADDRESS Union Memorial Hosp Balti, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-29-86	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery Pr. Anne	23d. LOCATION CITY OR TOWN COUNTY STATE Somerset	
24. FUNERAL DIRECTOR NAME ADDRESS Russell A. Fooks Salisbury MD	25a. DATE REC'D. BY REGISTRAR OCT 24 1986			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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2025 COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove certain papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Page 3 should be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified prior to burial, cremation, or other disposition of the body.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEROY G. ENGLE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>October 29, 1986</b>		2b. HOUR <b>6 00 A M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 22, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Convalesarium</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Henry Knott</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Parkville</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2803 Second Ave. 21234</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John B. Engle</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche M. Scarff</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>216 10 5246</b>		17. INFORMANT ADDRESS <b>Robert L. Engle, Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIO-</b>									
(c) <b>VASCULAR DIS.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>DEMERTIA</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that this hospital attended the deceased from <b>5/3</b> 19 <b>84</b> , to <b>10/29</b> 19 <b>86</b> , that (1) (we) lost saw the deceased alive on <b>10/24</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (do) not view the body after death.									
22b. SIGNATURE <b>[Signature]</b>					DEGREE		22c. DATE SIGNED <b>10/29/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Luis Rivera, MD</b>					22e. ADDRESS <b>5714 Harford Rd., Balto., MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/1/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fallston Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fallston, MD</b>		
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
4905 York Road Balto., MD 21212									

BP

100-100000

CHRY G. NGILE October 22, 1988

U.S. District Court for the District of Columbia

U.S. District Court for the District of Columbia

U.S. District Court for the District of Columbia

U.S. District Court for the District of Columbia

U.S. District Court for the District of Columbia

U.S. District Court for the District of Columbia

1

U.S. District Court for the District of Columbia

U.S. District Court for the District of Columbia

U.S. District Court for the District of Columbia



00-21130



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

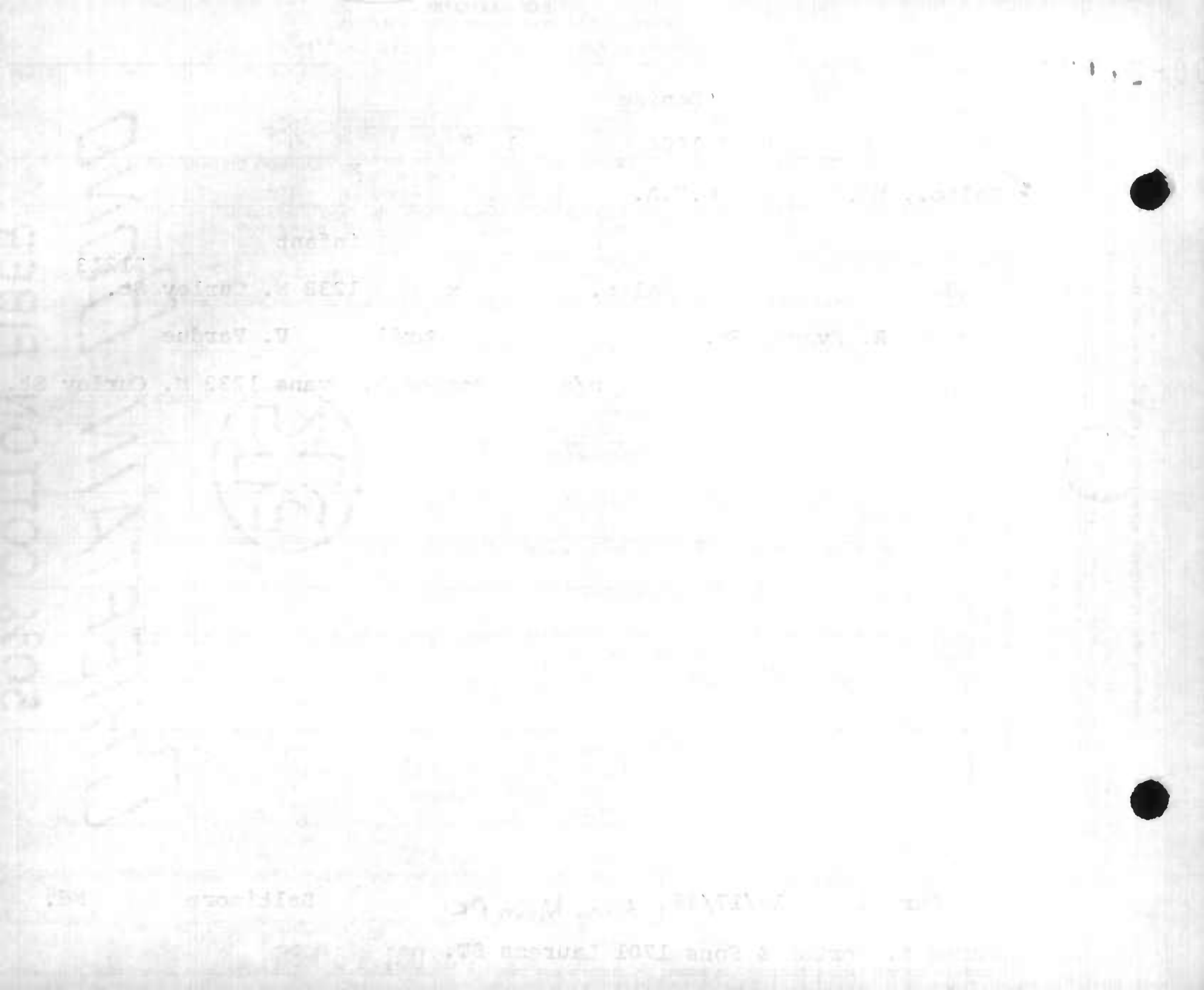
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M

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DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28099	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) April Denise Evans										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> 10 15 1986	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 9 7 1986		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 1 8		IF UNDER 1 YR. MONTHS DAYS 1 8		IF UNDER 24 HRS. HOURS MIN. 15 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) infant		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY ✓		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1232 N. Curley St.		21213	
14. FATHER'S NAME FIRST MIDDLE LAST Roscoe A. Evans, Jr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST April V. Pardue					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. n/a		17. INFORMANT ADDRESS Roscoe A. Evans 1232 N. Curley St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 10/15/86			
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.				ADDRESS 111 Penn St. Balto.MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/17/86		23c. NAME OF CEMETERY OR CREMATORY King Mem Pk.		23d. LOCATION CITY OR TOWN COUNTY MD.			
24. FUNERAL DIRECTOR NAME James A. Morton & Sons 1701 Laurens St.						25a. DATE REC'D. BY REGISTRAR OCT 16 1986		25b. REGISTRAR'S SIGNATURE 			



2  
00-22612

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove this page. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, for medical examiner's office notification.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Conrad</u> <u>Evans</u>									
2a. DATE OF DEATH MONTH DAY YEAR <u>10</u> <u>28</u> <u>86</u>		2b. HOUR <u>6:45 PM</u>							
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>5</u> <u>26</u> <u>57</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <u>29</u>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.			
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Maryland Cancer Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>unemployed</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Anne Arundel</u> 13c. CITY OR TOWN <u>Glen Burnie</u>									
14. FATHER'S NAME FIRST MIDDLE LAST <u>Roscoe</u> <u>NMI</u> <u>EVANS</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Dorothy</u> <u>N</u> <u>Morton</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <u>220-64-0493</u>		17. INFORMANT ADDRESS <u>Dorothy Evans 7955 Freetown Rd.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic rhabdomyosarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>rhabdomyosarcoma metastatic to the Central Nervous System</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>October 5</u> , 19 <u>86</u> , to <u>October 28</u> , 19 <u>86</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>October 28</u> , 19 <u>86</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did (did not) view the body after death.									
22b. SIGNATURE <u>Robert Fisher M.D.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>10/28/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert Fisher M.D.</u>		22e. ADDRESS <u>22 S. Greene St., Baltimore, MD 21201</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-31-86</u>		23c. NAME OF CEMETERY OR CRYPT <u>King Mem Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto Md.</u>			
24. FUNERAL DIRECTOR NAME <u>James A. Morton &amp; Sons</u>				ADDRESS <u>1701 Laurens Street</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 30 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH B. EVANS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 24 86</b>		2b. HOUR <b>4:25 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 22 1910</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Matthew Hailey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Desper</b>		13e. STREET ADDRESS, ZIP CODE <b>3031 Mondawmin Ave 21216</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-22-7212</b>		17. INFORMANT ADDRESS <b>Margarete Barksdale 3031 Mondawmin Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Infected Decubitus Ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Two weeks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Cranial Meningioma</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>9/3/86</b> 19____, to <b>10/24/86</b> 19____, that (1) (we) last saw the deceased alive on <b>10/24/86</b> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE <b>Lana S. Simpler</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/24/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SIMPLER</b>				22e. ADDRESS <b>MERCY HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/29/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Town Neck Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Severna Park Md</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>March Funeral Home West 4300 Wabash Avenue</b>			
25a. DATE REC'D. BY REGISTRAR <b>OCT 29 1986</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be marked as such.



86 28102  
REG NO

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
William C. Evans								October 8, 1986								7:05 <sup>A</sup> <sub>M</sub>			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR				8. IF UNDER 24 HRS.			
Male		White		Nov. 29, 1931				54				YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Baltimore, Md.		U. S. A.								Baltimore City, MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)																	
Baltimore		Francis Scott Key Hospital General Laborer-Packing Co.																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS											
Md.		---		Baltimore				21224 3017 E. Baltimore St.											
14. FATHER'S NAME									15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST William Albert Evans									FIRST MIDDLE LAST Lois Regina Walker										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
Yes				1947-49 218-26-8314				Baltimore, Md. 21224 Mrs. Marlene M. Evans-3017 E. Baltimore St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease																			
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Feb 27, 19 77, to October 7, 1986, that (I) (we) lost saw the deceased alive on Mar 18, 1986, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE														DEGREE		22c. DATE SIGNED			
MELITO M. TORRES, M.D.																10-9-86			
23a. PHYSICIAN'S NAME (TYPE OR PRINT)								23b. ADDRESS											
MELITO M. TORRES, M.D.								441 S. Ellwood Ave. Balto, Md 21224											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				10/11/86		St. Stanislaus Cem.				Baltimore, Maryland									
24. FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home																			
3000 E. Baltimore St., Balto., Md. 21224																			
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																			
OCT 9 1986																			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed with the assistance of a physician. The body must be retained by the hospital or attending physician.

BP





00-21035

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 28103

1. DECEASED NAME (TYPE OR PRINT) <b>Allen Russell Evernham</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-10-86</b>			2b. HOUR <b>3:15 A</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 24, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Convalesarium</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8014 Harford Road 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alex Evernham</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Benson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>		17. INFORMANT <b>Mrs. Angela V. Evernham</b>		ADDRESS <b>same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>IDIOPATHIC THROMBO- CYTOPENIC PURPURA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CARDIAC ARREST</b> <b>SENILE DEMENTIA</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT RECREATION <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) this hospital attended the deceased from <b>9-19</b> , 19 <b>86</b> , to <b>10-10</b> , 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>10-10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>RIVERA</b>			DEGREE			22b. DATE SIGNED <b>10/11/86</b>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RIVERA</b>			22d. ADDRESS <b>5714 HARFORD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>10/11/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1986</b>			
						25b. REGISTRAR'S SIGNATURE <b>Leonard J. Ruck</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-2132

DATE

TIME

Dec. 24, 1953

NO

Van, Jersey

U.S.A.

to

Mr. Tolson

Baltimore

Frederick

NY

501, Hartford Ave. 4123

Alex

Frederick

Frederick

Frederick

155-22-6045

Re. Alex A. V. Frederick, born 12/

10/17/53 Testimony of Frederick

Frederick, Inc. Baltimore, Maryland

00-21538

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28104

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
THOMASINA FALCON		female		black	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MONTH DAY YEAR		LAST BIRTHDAY YRS.		N. C.	
5 30 1953		33			
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
USA		WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
University Hospital		Unemployed			
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Md		Baltimore		2601 Woodland Avenue Apt B 21215	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Willie A. Falcon		Pauline Melton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-54-0462		Pauline Falcon 2426 Shirley Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Pre-eclampsia and abruptio placenta with complications					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Margarita A. Korell, M.D.		Assistant		10-17-86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/22/86		Md National Memorial Park	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
March Funeral Home West 4300 Wabash Avenue		OCT 20 1986			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURNED TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

51238



NOTICE

00-22135

FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28105

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
CHARLES				FANGMAN	10		24	1986	745P		M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE	WHITE		12 28 1892		93 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	U.S.A.				Baltimore City MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore	St. Agnes Hospital		Clerk		Highway Dept.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Maryland		--		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		800 S. Caton Avenue 21229				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME										
August		Fangman		Bertha		Schultz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
NO		216-05-9355		Vernon Fangman 13504 Holly Lane Ocean City Md. 21842								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>											<u>immediate</u>	
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) <u>Acute pulmonary edema</u>											<u>2 day</u>	
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
NA		NA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
		P.M. 19										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION								
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>86</u> , to <u>10/24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE										DEGREE		22c. DATE SIGNED
<u>Paul Garner, MD</u>										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10/24/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS		
Paul Garner, MD										St Agnes		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE				
Burial		10/28/86		Meadowridge Cemetery		Dorsey		Maryland				
24. FUNERAL DIRECTOR												
NAME 1630 Edmondson Ave. Catonsville, Md. 21228												
ADDRESS Leroy M. & Russell C. Witzke Funeral Home												
25. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE		
OCT 27 1986										<u>[Signature]</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ST. LOUIS, MO.

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Report of the  
Commissioner of the  
Bureau of the Census

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0-20959

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28106  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
RITA LERENE FARMER					OCTOBER 13, 1986				4:50am
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	White	MONTH DAY YEAR Feb. 26, 1926		60	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Johnstown, Pa.	U.S.A.			Baltimore City MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	Church Hospital, Inc.			Registered Nurse		Hospital			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. CITY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland	Baltimore	Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1913 Wareham Rd. (21222)			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS					
FIRST MIDDLE LAST Forest Coy Wilson		FIRST MIDDLE LAST Ida Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		217.20.6014		George C. Farmer (Husband) (Same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER OF LUNG WITH METASTASES</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 7, 1986</u> , to <u>OCTOBER 13, 1986</u> that (I) (we) last saw the deceased alive on <u>OCTOBER 13, 1986</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not see the body after death.)									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
		MD						10/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JONATHAN D. KUSHNER, M.D.		CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTO. MARYLAND 21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		10/16/1986		Green Mount Crematory		Baltimore Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Walter Brooks Bradley Inc., Dundalk, Md. 21222				OCT 14 1986					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "I", there is any injury, or other traumatic event, the medical examiner must be called at once.

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00-21450

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

28107

1 DECEASED NAME (TYPE OR PRINT) <b>GEORGE R. FARRELL</b>			2a DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 15-86</b>			2b HOUR <b>25<sup>00</sup>P.M.</b>			
1 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3-23-1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10a CITY OR TOWN OF DEATH <b>Balto. City</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Post Office</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>			13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>George R. Farrell</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Lieler</b>			13e STREET ADDRESS / ZIP CODE <b>1609 A Cantwell Rd., Balto. 21207</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR NO. IN CASES) <b>216-44-2867</b>		17 INFORMANT ADDRESS <b>R. Terence Farrell, 2901 Southern Ave. 21214</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>FREQUENT ASPIRATION PNEUMONIAS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>NEUROMUSCULAR WEAKNESS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>OCULT HYDROCEPHALUS - GENERAL DEBILITY</b>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (the hospital) attended the deceased from <b>JUNE</b> , 19 <b>72</b> , to <b>OCTOBER 15</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Joseph D. Notarangelo</b>					DEGREE <b>M.D.</b>		22c DATE SIGNED <b>10-15-1986</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH D. NOTARANGELO M.D.</b>					22e ADDRESS <b>301 ST. PAUL PLACE, BALTIMORE 21202</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>10-18-86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Balto. MD</b>		
24 FUNERAL DIRECTOR Name <b>John C. Miller, Inc., 6415 Belair Rd. 21206</b>						25 DATE REC'D. BY REGISTRAR <b>OCT 17 1986</b>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, please notify injury, or other traumatic event, the medical examiner must be notified.

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2023 COLTON LIBRARY

NOTICE 2002  
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NOTICE

2023

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28108

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Baby Girl				FAULCON	10 13 86					640 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
female	Black		MONTH DAY YEAR 10 12 86		1 day		MONTHS DAYS - 1		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Baltimore	U.S.A.				Baltimore city MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	South Baltimore General Hospital										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		932 Seagull Avenue / 21225			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Fred				FIRST MIDDLE LAST Gloria L Faulcon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) Anencephaly, Encephalocele

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-12-86, 1986, to 10-13, 1986, that (I) (we) last saw the deceased alive on 10-13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Sharif				MD		10-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Monther sharif				South Baltimore General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		10-23-86					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Anatomy Board				OCT 29 1986		Julia Gordon-Rodgers	
ADDRESS				Balto., Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES H. R. FEEHELEY, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/20/86</b>			2b. HOUR <b>1125pM</b>			
3. SEX <b>Male</b>		4. RACE <b>W White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 14, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 23 HRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital, Balto, MD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sheet Metal Mech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Local Un. 100</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>754 204th St. 21122</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Feeheley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Sapp</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>yes WW II</b>		16b. SOCIAL SECURITY NO. <b>216 12 6317</b>		17. INFORMANT ADDRESS <b>Dolores H. Feeheley (Same as 13a-e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lung cancer, metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic obstructive pulmonary disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>chronic obstructive pulmonary disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> 19 <b>86</b> to <b>10/20</b> 19 <b>86</b> , that (I) (we) saw the deceased give on <b>10/20</b> 19 <b>86</b> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE <b>Hyun Joseph Kim</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/20/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HYUN JOSEPH Kim</b>				22e. ADDRESS <b>Mercy Hospital, Balto MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Oct. 21, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process Inc</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Baltimore MD</b>			
24. FUNERAL DIRECTOR <b>McCully Funeral Home</b>				3204 Mountain Rd. <b>Pasadena, MD 21122</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 23 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 2 8 1 1 0

1. DECEASED NAME (TYPE OR PRINT) <b>Frances E. Feige</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/27/86</b>			2b. HOUR MIN. <b>10:30 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 8 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
11. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home/Domestic</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>118 Willo-Brook Dr. 21122</b>			15. MOTHER'S MAIDEN NAME <b>Catherine Zimmerman</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>212 26 7325</b>			17. INFORMANT <b>Earl Feige</b>			ADDRESS <b>(Same as 13a-e)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spontaneous Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Chronic S/P Pulmonary Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Resection for C.A.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
9a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/17/86</b> , 19____, to <b>Present</b> , 19____, that (I) (we) lost saw the deceased alive on <b>10/27/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Michael F. Plott, M.D.</b>						DEGREE		22c. DATE SIGNED <b>10/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL F. PLOTT, M.D.</b>						22e. ADDRESS <b>100 E. Pleasant St Baltimore MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Oct. 30, '86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore MD</b>		
24. FUNERAL DIRECTOR NAME <b>Mc Carthy FH</b>						3204 Mountain Rd Pasadena MD 21122			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201







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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the completed page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John Joseph Felbinger</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 13, 1986</b>			2b. HOUR <b>M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 31, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>5610 York Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5610 York Rd. 21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sigmund Felbinger</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cecelia Meehan</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>213 05 2583</b>		17. INFORMANT ADDRESS <b>622 Dorsey Rd. Balto., Md. 21222</b> <b>Audrey M. Grauch, Daughter</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Severe COPD</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>84</b> , to <b>Sept</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>Sept</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Paul M. Kelly MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>10/14/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>10/15/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Brudzinski Funeral Home PA 1407 Old Eastern Ave</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>			

BP.



00-21064

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28113  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Sarah Feldman</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10-07-86</b>		2b. HOUR <b>1107P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05-10-1899</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>87</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hevindele</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		13a. STATE <b>MD</b>	
13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>REUBEN FREED</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY REESE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>316-16-3005</b>		17. INFORMANT <b>MRS. LILLIAN ROMAGNI</b>		2113 S.W. 72ND AVE. DAVIE, FL 33317	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA, ANUS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/26 19 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <b>we</b> (this hospital) attended the deceased from <b>8/26</b> 19 <b>86</b> to <b>10/7</b> 19 <b>86</b> , that <b>we</b> (we) last saw the deceased alive on <b>10/7</b> 19 <b>86</b> , and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>we</b> (we) (did) (do not) view the body after death.							
22b. SIGNATURE <b>E. O. KU</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/8/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELITA O. KU</b>		22e. ADDRESS <b>HEVINDELE HEBREW GERIATRIC CENTER + HOSPITAL</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>OCT. 9, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI ZION</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS. INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1986</b>			
25b. REGISTRAR'S SIGNATURE							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical director, page 3 should be detached for use as the burial transit permit. Then the funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or death, a coronial investigation should be held.

MEDICAL CERTIFICATION

29

BP

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

0-20-19

00-19782

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28114  
REG. NO.

|   |   |   |   |  |  |   |  |   |
|---|---|---|---|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |   |
| FIRST MIDDLE LAST<br>MCCLELLAN R. FELLOWS   |   |   | MONTH DAY YEAR<br>SEPTEMBER 18, 1986  |  |  | 11:05 A   |  |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | 7. IF UNDER 1 YEAR  |  |   |
| Male  | Caucasian   | MONTH DAY YEAR<br>Mar 3 1926  | 60 YRS.   |  |  | MONTHS DAYS HOURS MIN.  |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |   |  |   |
| China   | U.S.A.  |   |   | BALTIMORE CITY MD.   |  |   |  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY          |   |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL  |   |   | Retired  |  |   | Proctor & Gammel                           |   |
| 13a. STATE  |   |   | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |   |
| VA.   |   |   | Fairfax   |  |  | McLean  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |   |  |   |
| McClellan C. Fellows  |   |   | Catherine Deahl   |  |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |   | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS   |  |   |
| yes   |   |   | 376-20-2961   |  |  | Harriet F. Rellows 8380 Greensboro Dr. McLean, Va.                  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>leukemia</u>   |   |   |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>15 minutes</u><br><u>2 weeks</u><br><u>3 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1</u>   |   |   |   |  |  |   |  |   |
| 19a. DATE OF OPERATION  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |
|   |   |   |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/7/86</u> to <u>9/18/86</u> , that (I) (we) last saw the deceased alive on <u>9/18/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |   |  |   |
| 22b. SIGNATURE<br><u>Cynthia S Cromer MD</u>  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><u>9/18/86</u>                                  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Cynthia S Cromer</u>  |   |   | 22e. ADDRESS<br><u>Johns Hopkins Hospital 601 N. Broadway Baltimore, MD 21205</u>   |  |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |
| Burial  |   |   | 9-23-86   |  | Ivy Hill Cemetery  |   | Alexandria, Virginia                       |   |
| 24. FUNERAL DIRECTOR<br>NAME  |   |   | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |
| Everly-Wheatley Funeral Home<br>1500 W. Braddock Rd. Alex. Va.  |   |   | SEP 29 1986   |  |  | Julia Davidson-Randall  |  |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event the death certificate must be no kind of case.

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00-21815

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Helen Rose Fendryk</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 21 '86</b>                     |   |   | 2b. HOUR<br><b>1830pm</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>08 26 '15</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore (City)</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mason F. Lord Nursing Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Croose-Blackwell</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>437 Honnel Street 21224</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Jakubowski</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Veronica Siwicki</b> |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> IF YES GIVE WAR OR DATES)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-1881</b>                           |   | 17. INFORMANT ADDRESS<br><b>J. Richard Fendryk 724 219th. St. 21122</b> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Renal Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>   |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 days</b><br><b>2 months</b><br><b>Years</b>                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><b>COPD, Dementia, ASCVD, Anemia</b>   |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>           |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE <input checked="" type="checkbox"/><br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>            |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> , 19 <b>86</b> , to <b>10/21</b> , 19 <b>86</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>10/21</b> , 19 <b>86</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above <input type="checkbox"/> (I) <input type="checkbox"/> (we) did not see the body after death. |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Melvin Hector</b>   |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/22/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Melvin Hector</b>  |  |  | 22e. ADDRESS<br><b>Francis Scott Key Med Center - Baltimore</b>          |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>10-25-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b>       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk, Balto., Co., Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1986</b>                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |  |  |

BP



00-230111

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 2 3 1 1 0

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William J. Feuchter</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>OCTOBER 29, 1986</b>                                     |  | 2b. HOUR<br>A. <b>10:35</b><br>M.                     |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>SEPT. 21, 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b><br>YRS. MONTHS DAYS HOURS MIN.          |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>719 NORTH KENWOOD AVE.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNGER/MANN</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BOAT YARD</b> |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <b>719 NORTH KENWOOD AVE. 21205</b>                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN FEUCHTER</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET TEICHMAN</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, NO OR UNKNOWN) <b>NO</b><br>(IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.<br><b>216 056814</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>                                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio - Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |   |   |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Adenocarcinoma of Salivary gland / mandible</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>9/86</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Adenocarcinoma mandible</b>  |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>A. Sclama</b>   |   | DEGREE <b>MD</b>  |   | 22c. DATE SIGNED<br><b>OCT. 30, 1986</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANTHONY SCLAMA</b>   |   | 22e. ADDRESS<br><b>9101 FRANKLIN SQUARE DRIVE</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   | 23b. DATE<br><b>10-31-1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORRISLAND MEM PK</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MD.</b>            |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES ROAD</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 - 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Lia Finken-Pandora</i>                              |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this should be referred to the police for an official report.

BP \_\_\_\_\_

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]*

0-21259

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 1 7

REG. NO.

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Alice L. Fields</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 10-14 8</b>                                       |   |  | 2b. HOUR<br><b>6:40 PM</b>  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 6 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b> |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>  |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>PVT. FAMILY</b>  |  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <b>MARYLAND</b> 16b. COUNTY <b>BALTIMORE</b> 16c. CITY OR TOWN <b>BALTIMORE</b>   |  |   | 17. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 18. STREET ADDRESS / ZIP CODE <b>MARYLAND 21217</b>   |  |   |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD H. FIELDS</b>   |  |   | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH MOORE</b>                            |   |  | 21. 2834 RIGGS AVENUE, BALTIMORE,   |  |   |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO.</b>   |  | 23. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>217-22-3075</b>   |  | 24. INFORMANT<br>ADDRESS<br><b>BALTIMORE, MARYLAND 21207</b><br><b>GEORGE E. FIELDS 4600 SPRINGDALE AVENUE</b>  |  |   |  |   |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure, Anemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio-sclerotic Cardiovascular Disease</b>  |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |   |  |   |  |   |  |   |  |
| 26. DATE OF OPERATION   |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |   |  |
| 33. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 36. I certify that (I) (this hospital) attended the deceased from <b>10-14</b> , 19 <b>86</b> , to <b>10-14</b> , 19 <b>86</b> , that (I) <del>last</del> saw the deceased alive on <b>10-14</b> , 19 <b>86</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will</del> (did) <del>not</del> view the body after death. |  |   |  |   |  |   |  |   |  |
| 37. SIGNATURE<br><b>Rosita R. Cruz</b>  |  | 38. DEGREE<br><b>M.D.</b>   |  | 39. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>            |  | 40. DATE SIGNED<br><b>10-14-86</b>  |  |   |  |
| 41. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROSITA R. CRUZ</b>   |  | 42. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |  |   |  |   |  |   |  |
| 43. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 44. DATE<br><b>10/17/86</b>   |  | 45. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PARK</b>   |  | 46. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>   |  |   |  |
| 47. FUNERAL HOME, INC.<br>NAME ADDRESS<br><b>2501 GWYNNS FALLS PKWY. BALTO. MD. 21216</b>   |  |   |  | 48. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1986</b>  |  | 49. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

MEDICAL CERTIFICATION

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BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or letter with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

0-21157

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mildred Fields</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 12, 1986</b>  |  |   |  | 2b. HOUR<br><b>6:40AM</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2- 17-- 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNK</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UNK</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>CENTRE NURSING HOME 21201</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK REDDICK</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLA SANDERS</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>UNK</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>GRACE FRANKLIN 1803 W. NORTH AVE. 21217</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebrovascular Accident</b><br>APPROXIMATE INTERVAL<br><b>30 Minutes</b><br><b>2 Weeks</b>  |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>September 19 86 October 12 86</b>   |  |   |  |   |  |
| 22a. I certify that (I, <input checked="" type="checkbox"/> this hospital) attended the deceased from <b>September 19 86</b> , to <b>October 12 86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 12 19 86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I, (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Lih-Jiau Chen M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>10/12/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LH-JIAU CHEN</b>  |  |   |  | 22e. ADDRESS<br><b>G/O Maryland General Hospital</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-17-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EASTVIEW CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MARCH F/H EAST 1101 E. NORTH AVENUE</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copy of page 1 and 2 and place in envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, medical examiner must be notified at once.

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RECEIVED

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please forward the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |  |   | REG. NO.   |   |
|--|---|--|---|--|---|
| 1. FOR STATE REGISTRAR   |   |  | 8028119   |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARDEL FINLET (Finley)  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 8, 1986  |  | 2b. HOUR<br>6:30 P.M.   |
| 3 SEX<br>M   | 4 RACE<br>B   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 24 17  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Georgia   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.s.a.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Finley  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Hudgins                                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>257037652  | 17. INFORMANT ADDRESS<br>Mabel E. Jones 733 Roundview Road                                      |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ESOPHAGAL CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>6 MONTHS</u>  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>NONE</u>  |   |  |   |  |   |
| 19a. DATE OF OPERATION<br><u>NONE</u>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>NONE</u>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/10/86</u> , 19 <u>86</u> , to <u>10/8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |   |  |   |  |   |
| 22b. SIGNATURE<br><u>Raymond Schettino</u>   |   | DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>RAYMOND SCHETTINO</u>  |   | 22e. ADDRESS<br><u>601 W. BROADWAY, Johns Hopkins</u>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>Burial</u>   |   | 23b. DATE<br><u>10/13/86</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Arbutus Baltimore Maryland</u>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Wm. C. March Funeral Home Inc. 1101 E. North Ave.</u>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 10 1986</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |

- 20682

7

100% COTTON OVERSEED

023188 NOV

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23120

1- FOR  
STATE  
REGISTRAR

2- BASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

GERALDINE

FITZGERALD

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 10 25 19 86 2b. HOUR M 1:10 A

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE PRONOUNCED DEAD

Female

Black

8 20 60

26 YRS.

MONTHS DAYS HOURS MIN.

10 26 19 86 1:10 A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Virginia

U.S.

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

Baltimore

236 S. Dallas Ct.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

Md.

Balto.

YES ☐ NO ☐

236 S. Dallas Court 21231

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

Nettie Fitzgerald

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Unkn.

Herman Ross

236 Dallas Ct.S. Balto., Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Fatty liver and pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) Alcoholism

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

WHILE ☐ NOT WHILE ☐ AT WORK

P.M. 19

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE SIGNED 10-26-86

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY STATE

Removal

10-29-86

24. FUNERAL DIRECTOR

NAME

ADDRESS

Anatomy Board

Balto., Md.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

NOV 05 1986

John Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

UNUS. M. 100-40




00-21150

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

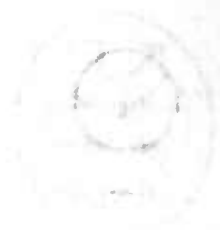
|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Dave Flowers, Sr.</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 14, 1986</b>                                  |  | 2b. HOUR<br><b>5:05 PM</b>   |
| 3 SEX<br><b>male</b>   | 4. RACE<br><b>black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 23 1911</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Public Health</b>  |
| 13a. STATE<br><b>Md</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2453 Frances Street 21217</b>                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Flowers</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Angela Thomas</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219-20-8390</b>  |   | 17. INFORMANT ADDRESS<br><b>John Dave Flowers, Sr 1745 N. Carey Street</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal and Metastatic Carcinoma From the</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Prostate</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 12, 19 86</b> , to <b>October 14, 19 86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 14, 19 86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (If we) (did) <input checked="" type="checkbox"/> view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>10/14/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. S. AMAN</b>   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>10/18/86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co Md</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>March Funeral Home West 4300 Wabash Avenue</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1986</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 when any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

08-2094

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |   |   |  |
|---|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY MILDRED FLYNN</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>10-9-1986</b>                   |   |  | 2b. HOUR <b>1:50P. M.</b>   |   |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>11-8-1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ind.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                    |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>113 S. Poppleton St. 21201</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Key Punch Operator</b>           |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>State of Ind.</b>  |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) (1a. STATE) <b>Ind.</b>  |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |   | 13e. STREET ADDRESS / ZIP CODE <b>113 S. Poppleton St. 21201</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>James J. Flynn, Sr.</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Thomas Agnes Donohoe</b>  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |   | 16b. SOCIAL SECURITY NO. <b>1</b>   |  | 17. INFORMANT ADDRESS <b>21201 Margaret Leekin Flynn 113 S. Poppleton St</b>                      |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Collapse (Respiratory)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Marked A.S.C.D.</b><br>(c) <b>Cancerous ulceration</b> |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b><br><b>years</b>                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SENILITY</b>  |  |  |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 4/86</b> to <b>October 9/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |   |   |  |
| 22b. SIGNATURE OF PHYSICIAN <b>Henry Armanas MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |   |   |  | 22c. DATE SIGNED <b>10.10.86</b>  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HENRY ARMANAS</b>  |  |  |   |   |  | 22e. ADDRESS <b>1934 Wilken Ave. Baltimore, Md 21223</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>Burial</b>   |  |  | 23b. DATE <b>10-13-1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>                        |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Ind.</b> |   |  |
| 24. FUNERAL DIRECTOR NAME <b>John L. Connor &amp; Son, Inc.</b> ADDRESS <b>901 Madison St. Balt. Md. 21223</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1986</b> 25b. REGISTRAR'S SIGNATURE <b>John L. Connor</b> |   |   |  |

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

100-100000-100000

100-100000-100000



00-21569

FOR  
STATE  
REGISTRAR

Maybelle R. Foote

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MAYBELLE Rosalyn Foote   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 19 86                        |   |  | 2b. HOUR<br>6:31 P.M.  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 15 08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  |  |   |  |  |   |  |  |
| 13b. COUNTY<br>A.A. Co.   |  | 13c. CITY OR TOWN<br>Pasadena  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>216 C Street 21122   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James W. Wilson   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lenoa Bostain  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218 12 0163   |  | 17. INFORMANT<br>ADDRESS<br>21122<br>Martin E. Foote 216 C Street Pasadena, Md.   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>   |  |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Immediately</u>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Myelophocytic Leukemia</u>   |  |  |  |   |  |  |   | months   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acute Gastrointestinal Bleeding</u>  |  |  |  |   |  |  |   | days   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 19, 1986</u> to <u>Oct 19, 1986</u> , that (I) (we) last saw the deceased alive on <u>Oct 19, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>Wm. H. Weiss, MD  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>10/19/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wm. H. Weiss, MD   |  |  |  |   |  | 22e. ADDRESS<br>Univ. of MD Hospital Balto, MD   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>10/23/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial pk |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonc  |  |  |  |   |  | ADDRESS<br>4001 Ritchie Hwy Balto Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1986   |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |   |  |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

CONFIDENTIAL



00-20721

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 8 1 2 4

|   |  |                         |  |  |  |   |  |  |   |  |  |   |  |  |
|---|--|-------------------------|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MORRIS E. FOOTE Jr</b>   |  |                         | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>9</b> YEAR <b>86</b>   |  |  | 2b. HOUR<br><b>1504M</b>  |  |  |   |  |  |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>22</b> YEAR <b>23</b>        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |   | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>  |  |   |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Post Office</b>   |  |  |   |  |  |
| 13a. STATE<br><b>MD</b>   |  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3025 Harlem Ave 21216</b>    |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Morris</b> MIDDLE <b>E.</b> LAST <b>Foote</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Admana</b> MIDDLE <b>E.</b> LAST <b>Winder</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-16-5314</b>  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Doris V. Foote 3025 Harlem Ave</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Advanced Small Cell Carcinoma of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |                         |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |  |
| MEDICAL CERTIFICATION   |  |                         |  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/18</b> 19 <b>86</b> to <b>10/9</b> 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/8</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |                         |  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Nisha Soprey</b>   |  |                         |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NISHA SOPREY</b>  |  |                         |  |  |  |   |  | 22e. ADDRESS<br><b>2300 Garrison Blvd. MD 21216</b>  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>10/14/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet</b>  |  |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Owings Mills</b> COUNTY <b>MD</b> STATE <b>MD</b>   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>March Funeral Home West 4300 Wabash Avenue</b>   |  |                         |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a certain time after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 3 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

00-50551

RECEIVED  
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |                                      |       |
|--|---|---|--|--------------------------------------|-------|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH   |  | 2b. HOUR                             |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | MONTH DAY YEAR  |  | 2b. HOUR                             |       |
| LEONA C. FORD  |   | 10 19 86  |  | 2330 M                               |       |
| 3 SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE   | 7. BALTIMORE CITY OR COUNTY OF DEATH |       |
| Female   | White   | MONTH DAY YEAR  | 69 YRS.  | Baltimore City MD.                   |       |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |       |
| Baltimore  | St. Agnes Hospital                                      | Tie Cutter  |  | Men Apparel                          |       |
| 13a. STATE   | 13b. CITY OR TOWN                                       | 13c. INSIDE CITY LIMITS?  | 13d. STREET ADDRESS / ZIP CODE                                 |                                      |       |
| Maryland   | Baltimore   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             | 1201 Ten Oaks Road 21227                                       |                                      |       |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |                                      |       |
| FIRST MIDDLE LAST  | FIRST MIDDLE LAST                                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) |  |                                      |       |
| Newman   | Laura   | 16b. SOCIAL SECURITY NO.  |  |                                      |       |
|  | Nunnely   | 215-24-2897   |  |                                      |       |
| 17. INFORMANT  |   | 17. ADDRESS   |  |                                      |       |
| Rosemary L. Perryman   |   | 1201 Ten Oaks Rd. 21227   |  |                                      |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |   |  |                                      |       |
| PART I. DEATH WAS CAUSED BY:   |   |   |  |                                      |       |
| IMMEDIATE CAUSE (a) POLYCYTHEMIA VERA  |   |   |  |                                      |       |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |   |   |  |                                      |       |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |   |   |  |                                      |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |   |   |  |                                      |       |
| OSTEOPOROSIS, HYPERTENSION   |   |   |  |                                      |       |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                      |       |
|  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                      |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |  |                                      |       |
|  | HOUR A.M. MONTH DAY YEAR                                |   |  |                                      |       |
|  | P.M. 19   |   |  |                                      |       |
| 21d. INJURY OCCURRED   | 21e. PLACE OF INJURY                                    | 21f. LOCATION   |  |                                      |       |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          | STREET CITY OR TOWN COUNTY STATE  |  |                                      |       |
| 22a. I certify that (I) (this hospital) attended the deceased from 5, 19 85, to 10, 19 86, that (I) (we) last saw the deceased alive on 10/14, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |   |   |  |                                      |       |
| 22b. SIGNATURE   |   | DEGREE  |  | 22c. DATE SIGNED                     |       |
| Meyer R. Heyman M.D.   |   |   |  | 10 20 86                             |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |                                      |       |
| Meyer Heyman   |   | Room P3H20 University Hosp. 3rd Fl. South Hosp.   |  |                                      |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION  | COUNTY                               | STATE |
| Burial   | 10/23/86  | Loudon Park Cemetery  | Baltimore  | Maryland                             |       |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE                                     |                                      |       |
| NAME   |   | 21229   |  |                                      |       |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |   | OCT 22 1986   |  |                                      |       |

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00-22479

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |  |   |  |  |                              |   |
|---|---|--|---|--|---|--|--|------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH   | MONTH  | DAY  | YEAR                         | 2b. HOUR  |
| MORTON  |   |  |   | FORMAN   | OCTOBER   | 23,  | 1986   |                              | 5:30 A.M.   |
| 3. SEX  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |                              | IF UNDER 24 HRS.  |
| MALE  | CAUCASIAN   |  | AUGUST 10, 1910   |  | 76  |  | MONTHS DAYS  |                              | HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |                              |   |
| MARYLAND  | U. S. A.  |  |   |  | BALTIMORE CITY MD.  |  |  |                              |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)     |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                              |   |
| BALTO   | VILLA ST. MICHAEL NURSING HOME  |  |   |  | SALESMAN  |  | FURNITURE  |                              |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |  |   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |                              |   |
| 13a. STATE  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 6405 DORAL DR., APT. E (21209)   |  |                              |   |
| MD  |   |  |   | BALTO  |   |  |  |                              |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                  |   |  |  |                              |   |
| SAMUEL FORMAN   |   |  |   | LEAH ROSENSTEIN  |   |  |  |                              |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |   |  |  |                              |   |
| NO  |   | 578-05-8539  |   | MR. VICTOR FORMAN 6803 HUNT CT. 21209  |   |  |  |                              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Amyotrophic lateral Sclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |   |  |   |  |  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1+ years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |  |   |  |   |  |  |                              |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                              |   |
|   |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                              |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |                              |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |                              |   |
|   |   |  |   |  |   |  |  |                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-20-86</u> to <u>10-23-86</u> , that (I) (we) last saw the deceased alive on <u>10-3-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                   |   |  |   |  |   |  |  |                              |   |
| 22b. SIGNATURE<br><u>Harold Bob</u>   |   |  |   | DEGREE<br>MD   |   | ATTENDING PHYSICIAN<br>MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10-24-86 |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold Bob MD  |   |  |   | 22e. ADDRESS<br>7220 Park Heights Avenue                                       |   |  |  |                              |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                              |   |
| BURIAL  |   | 10/24/86   |   | SHAAREI ZION   |   | ROSEDALE BALTO. MD   |  |                              |   |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215  |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |                              |   |
|   |   |  |   | OCT 29 1986  |   |  |  |                              |   |





00-21667

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Russell B Forrest   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 16 86 |   |  | 2b. HOUR<br>11:15 PM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 7 17   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Va  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Roofing  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>J.B. Roofing Co.   |  | 13a. STATE<br>MD   |   |   |  |  |  |
| 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>926 N. Carrollton Ave 21017  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Moses R Forrest   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Beatrice Grant  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II   |   | 17. INFORMANT<br>Mrs. Mary Forrest 2208 Lynhurst Ave 21216  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic Bladder Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-3 19 86 to 10-16 19 86, that (I) (we) last saw the deceased alive on 10-16 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Mary T. Behrens   |  | DEGREE   |   | 22c. DATE SIGNED<br>10-16-86  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mary T. Behrens  |  | 22e. ADDRESS<br>University Hospital 225 Green St   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CITY)<br>Burial   |  | 23b. DATE<br>10-20-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Uti. Cem  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bwings Mills Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ 2222 W. North Ave.   |  | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed with the death certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH: 16 60M 7/84

(VRA 15, 4)

OCT 21 1986

76215-00

00-22082

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR <u>per phone</u>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BABY GIRL FOSTER</b>  |  |   |  | 2b. HOUR P<br><b>1:34M</b>  |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 6 86</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>               |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>BALTO</b>  |  |   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS, ZIP CODE <b>7106 E. Biddle St. 21213</b>    |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Zachary Small</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mabel Foster</b>  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEVERE LUNG IMMATUREITY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PREMATURITY (23 wks gestation)</b>   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hours</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 6</b> , 19 <b>86</b> , to <b>Oct 6</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>Oct 6</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <b>10/6/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard Orel, MD</b>   |  |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSP 600N WOLFE ST BALT, MD</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>10-16-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Anatomy Board</b>  |  |   |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1986</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>               |  |

BP

00-35053

00-22775

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR THOMAS EDWARD FRANCE

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS EDWARD FRANCE  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-30-1986                                   |  | 2b. HOUR<br>10:15 PM  |
| 1. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 10, 1910   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant - N. |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Barton-Benson  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Catonsville   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |
| 13e. STREET ADDRESS / ZIP CODE<br>37 Dunvegan Road 21228   |   |   | 15. MOTHER'S MAIDEN NAME<br>Daisy Seidenstricker                                    |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   |   | 16b. SOCIAL SECURITY NO.<br>226-01-5328A  |  |   |
| 17. INFORMANT<br>Julia France  |   |   | ADDRESS<br>Same as # 13   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular disease</i>  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>weeks.   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Left middle cerebral artery thrombosis</i>  |   |   |   |  | days  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>SIP MI, CHF, basilar artery aneurysm, ulcerative colitis</i>  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-3</i> , 19 <i>86</i> , to <i>10-30</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>10-30</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><i>Dr. Richard Fenton</i>  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>10-30-86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Richard Fenton  |   | 22e. ADDRESS<br>900 Caton Ave, Balt MD 21229.   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |   | 23b. DATE<br>10/31/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory                             |   |
| 23d. LOCATION<br>CITY OR TOWN<br>Catonsville   |   | COUNTY<br>Maryland  |   | STATE  |   |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1986   |   |
| 25b. REGISTRAR'S SIGNATURE   |   |   |   |  |   |





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nathaniel E. Frazier  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-3-86   |  | 2b. HOUR<br>12 <sup>15</sup> PM   |   |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 16 10   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John L. Deaton Nursing Home |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.  |   |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE<br>Md   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel   |  | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>haberer  |   |
| 13a. COUNTY<br>VBA/10  |  | 13b. CITY OR TOWN<br>Woodhar   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Burk  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   |
| 16b. SOCIAL SECURITY NO.<br>705-10-9119  |  | 17. INFORMANT<br>Emma Berry  |  | ADDRESS<br>7117 Rudisill Ct Apt 2120  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mos |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Colon Cancer with obstruction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cancer of the Prostate with Metastases  |  |  |  |   | 4 mos<br>2 mos  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a   |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/23, 19 86, to 10/3, 19 86, that (I) (we) last saw the deceased alive on 10/3, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br>Valerie Barnwell   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>10/3/86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Valerie Barnwell  |  | 22e. ADDRESS<br>615 S. Charles St. Baltimore 2120  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/8/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |   |
| 23d. LOCATION<br>CITY OR TOWN<br>Balto   |  | COUNTY<br>Co   |  | STATE<br>Md   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue   |  | 25a. DATE REC'D. BY REGISTRAR<br>001011986   |  |   |   |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |   |

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*





00-21978

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28131

|  |  |  |   |   |  |   |   |   |  |
|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HERBERT                               |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 17 86                 |   |  | 2b. HOUR<br>245 PM  |   |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 23 26  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                        |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL OF BALTIMORE |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF EMPLOYED |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>LADIES ACCESS.             |  |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY<br>BALTO  |   | 13c. CITY OR TOWN<br>BALTIMORE                                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH                             |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SYLVIA POSNER  |   |  | 13e. STREET ADDRESS / ZIP CODE<br>2320 FARRINGTON ROAD #21209                     |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII |   | 17. INFORMANT<br>MRS. SORETTA FRIEDMAN<br>2320 FARRINGTON RD. #21209 |   |   |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTASES TO BRAIN OF LUNG CANCER</u>   |  | <u>6 months</u>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>STATUS EPILEPTICUS DUE TO LUNG CANCER METASTASIS</u>   |  | <u>2 days</u>   |

|   |  |   |  |
|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>COMATOSE - UNABLE TO CLEAR OWN SECRETIONS</u>   |  |   |  |
| 19a. DATE OF OPERATION<br><u>LUNG CANCER</u><br><u>3/18/86</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>LUNG CANCER</u>  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>245 P.M. 10 17 86</u>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>---</u>  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>---</u>  |  |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>---</u>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>---</u>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 13 86</u> to <u>10 17 86</u> , that (I) (we) last saw the deceased alive on <u>10 17 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><u>Michèle J. Gottlieb</u>  |  | 22c. DATE SIGNED<br><u>10/17/86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MICHELE J. GOTTLIEB</u>   |  | 22e. ADDRESS<br><u>6204 GREENSPRING AVENUE</u>  |  |

|   |  |                       |  |   |  |  |  |
|---|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>10-20-86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH EL MEMORIAL PARK |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RANDALLSTOWN BALTO. MD |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 23 1986                |  | 25b. REGISTRAR'S SIGNATURE<br><u>Brandon [Signature]</u>             |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VIA 15, 4)

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Great West Publishing

RECEIVED NOV 10 1964

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28132

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARION (MARIAN) FRISHMAN   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 17, 1986                             |  | 2b. HOUR<br>2:45A.  |
| 3. SEX<br>FEMALE  | 4. RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MAY 5, 1924 YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                        |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>111 HAMLET HILL RD. APT. 211 (21210) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Food Service | 12b. KIND OF BUSINESS OR INDUSTRY<br>COMMERCIAL EQUIPMENT                            |   |
| 13a. STATE<br>MARYLAND  |   |   | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>BALTO   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL COHEN  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CELIA YOSKIN   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>216-16-1760   |  | 17. INFORMANT ADDRESS<br>02067<br>JOHN FRISHMAN 1 BOULDER LANE SHARON, MASS.         |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer lungs with</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic lesion</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>one year</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1977</u> to <u>Oct 17, 1986</u> , that (I) (we) lost<br>saw the deceased alive on <u>Oct 17, 1986</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                           |   |   |  |  |   |
| 22b. SIGNATURE<br><u>David J. Miller M.D.</u>   |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>10/17/86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David J. Miller  |   | 22e. ADDRESS<br>10212 S. Delaplace  |  | 22f. PHYSICIAN'S SIGNATURE<br><u>David J. Miller</u>                                 |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |   | 23b. DATE<br>10-20-86<br>XXXXX  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HAR SINAI CEM                                  |   |
| 23d. LOCATION<br>OWINGS MILLS   |   | COUNTY<br>BALTO   |  | STATE<br>MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 23 1986                                     |  | 25b. REGISTRAR'S SIGNATURE<br><u>David J. Miller</u>            |

MEDICAL CERTIFICATION

29

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages 4 and 5 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint outlines of a table or grid are visible in the upper left corner.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 28133  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EVA NMN FROMM</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>10/10/86</b>   |   |  | 2b. HOUR<br><b>7:35AM</b>  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4/25/10</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>201 Brookside Drive 21228</b>                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Matulaitis</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Nauyalis</b>                            |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-03-5637</b>  |  | 17. INFORMANT<br><b>Elaine Adams</b>  |   | 18. ADDRESS<br><b>10879 Clarksville Pike<br/>Columbia, MD. 21044</b>                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Replaced Cerebral Vessel</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Stroke</b> |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Days</b><br><b>2 Days</b><br><b>Unknown</b>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>72</b> , to <b>10/10</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                     |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Cliff Ratliff Jr</b>  |  |  |  |   | DEGREE<br><b>MD</b>   |   |  | 22c. DATE SIGNED<br><b>10/10/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CLIFF RATLIFF JR</b>   |  |  |  |   | 22e. ADDRESS<br><b>Baltimore, MD.<br/>5772 Westview Mall</b>                                    |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/13/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Maryland</b>                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Russell C. Witzke Funeral Homes P.A.<br/>1630 Edmondson Avenue, Catonsville, MD. 21228</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Gina Anderson</b>   |  |

BP

10/10/00

10/10/00

10/10/00



10/10/00



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-22960

|  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Joel (NMI) Fulmer  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 31 86   |  | 2b. HOUR<br>1200PM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>06 29 1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Stoker                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Mfrgr.   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Dundalk   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>11 Centre Ave. / 21222  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William W. Fulmer   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Minnie Kauber  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>350/18/8772  |  | 17. INFORMANT ADDRESS<br>Richard Lessig 13 Admiral Blvd. / 21222 Balto., Md.                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.  |  |  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia, aspiration</u>   |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Difficulty swallowing</u>  |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple prior lacunar cerebrovascular accidents</u>   |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dementia, COPD</u>   |  |  |  |  |  |  |  |   |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>N/A  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>N/A   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> 19 <u>86</u> to <u>10/31</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/31</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Melvin Hector  |  |  |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>10/31/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Melvin Hector   |  |  |  |  |  | 22e. ADDRESS<br>Francis Scott Key Medical Center Baltimore                                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>11/3/1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Walter Brooks Bradley Inc. Balto., Md. 21222  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 - 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Anderson-Randall  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 4 and 2, should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, involved call a coroner. A coroner must be notified if any of the following conditions exist:

- 1. Death occurred within 24 hours after injury or other traumatic event.
- 2. Death occurred within 24 hours after a fall from a height of 20 feet or more.
- 3. Death occurred within 24 hours after a fire or explosion.
- 4. Death occurred within 24 hours after a motor vehicle accident.
- 5. Death occurred within 24 hours after a drowning.
- 6. Death occurred within 24 hours after a suicide.
- 7. Death occurred within 24 hours after a homicide.
- 8. Death occurred within 24 hours after a natural disaster.
- 9. Death occurred within 24 hours after a riot or civil disturbance.
- 10. Death occurred within 24 hours after a terrorist attack.
- 11. Death occurred within 24 hours after a chemical, biological, or radiological attack.
- 12. Death occurred within 24 hours after a nuclear accident.
- 13. Death occurred within 24 hours after a major fire.
- 14. Death occurred within 24 hours after a major explosion.
- 15. Death occurred within 24 hours after a major flood.
- 16. Death occurred within 24 hours after a major earthquake.
- 17. Death occurred within 24 hours after a major hurricane.
- 18. Death occurred within 24 hours after a major typhoon.
- 19. Death occurred within 24 hours after a major tsunami.
- 20. Death occurred within 24 hours after a major volcanic eruption.
- 21. Death occurred within 24 hours after a major meteorite impact.
- 22. Death occurred within 24 hours after a major asteroid impact.
- 23. Death occurred within 24 hours after a major comet impact.
- 24. Death occurred within 24 hours after a major solar flare.
- 25. Death occurred within 24 hours after a major solar storm.
- 26. Death occurred within 24 hours after a major space weather event.
- 27. Death occurred within 24 hours after a major climate change event.
- 28. Death occurred within 24 hours after a major environmental disaster.
- 29. Death occurred within 24 hours after a major natural disaster.
- 30. Death occurred within 24 hours after a major human-made disaster.

00-5500

4-50-05-10-05

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00-21987

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8028135

|  |  |  |   |  |                                  |
|--|--|--|---|--|----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>FANNIE F. FULLWOOD |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>10-18-86                     |  | 2b HOUR<br>305 PM                |
| 3 SEX<br>F   | 4 RACE<br>B  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>11 19 03  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS                       |                                  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                | 7b CITIZEN OF WHAT COUNTRY?<br>USA   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.      |                                  |
| 10 CITY OR TOWN OF DEATH<br>BALT. CITY                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSPITAL, INC |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE<br>412 MD  |  |  | 13b COUNTY<br>BALT. CITY  | 13c CITY OR TOWN<br>BALTIMORE                                  |                                  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>? ? ?                             |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Webster |  |                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)        |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>118-14-1402  |   | 17 INFORMANT<br>ADDRESS<br>Joseph Pender 1032 Wilmot Ct. 21201 |                                  |

|  |  |  |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Restrictive cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|   |  |   |   |
|---|--|---|---|
| 19a DATE OF OPERATION<br>10-14-86   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Recurrent Colon Carcinoma | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Sept 14</u> , 19 <u>86</u> , to <u>Oct 18</u> , 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>Oct 18</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. |  |   |   |
| 22b SIGNATURE<br><u>Mark Kligman</u>  | DEGREE   | 22c DATE SIGNED<br>10-18-86   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARK KLIGMAN  | 22e ADDRESS<br>2518 RECLIM RD<br>BALTIMORE, MD 21207                         |   |   |

|  |                      |  |  |
|--|----------------------|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial              | 23b DATE<br>10/22/86 | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lansdowns Md. |
| 24 FUNERAL DIRECTOR<br>NAME<br>Chas. A. Rice FSPA 1300 Eutaw Place |                      | 25a DATE REC'D BY REGISTRAR<br>OCT 23 1986             |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0-21104

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

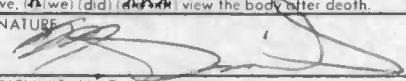
28130

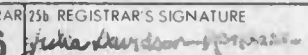
1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary</b>  |  | FIRST MIDDLE LAST<br><b>Fulton</b>  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 10, 1986</b>  |  | 2b HOUR<br><b>6:50 P.M.</b>  |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 22 86</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>100</b> YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b> |  | 13b COUNTY<br><b>Baltimore</b>  |  | 13c CITY OR TOWN<br><b>Baltimore</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNK</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNK</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  |
| 16b SOCIAL SECURITY NO.<br><b>UNK</b>  |  | 17 INFORMANT ADDRESS<br><b>RICHARD JASPER 37N ELLAMONT ST. 21229</b>  |  |  |  |  |  |

|  |  |  |  |
|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |  |
| 912<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Probable Aspiration</b> |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)                            |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
**Anemia; Congestive heart failure; Gastrointestinal bleed; Dehydration.**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                     |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19           |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 10, 19 86</b> to <b>October 10, 19 86</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>October 10, 19 86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |  |  |  |  |  |
| 22b SIGNATURE<br>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>10/10/86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. S. Simon</b>   |  |  |  | 22e ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |  |

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                 |  | 23b DATE<br><b>10-16-86</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>EASTVIEW CEMETERY</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MARCH F/H 1101 E. NORTH AVENUE</b> |  |                             |  | 25a DATE REC'D. BY REGISTRAR<br><b>OCT 15 1986</b>            |  | 25b REGISTRAR'S SIGNATURE<br> |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 31 is marked or item 18 shows any injury, or other information, and the medical examiner's name is signed at the bottom of the certificate, the medical examiner must be notified.



00-20688

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28137

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles B. Funk</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 6, 1986</b>                                   |  | 2b. HOUR<br><b>7 P M</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 3, 1918</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALT US.A.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto.</b> MD.                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3213 E. Fairmount Street</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>mechanic</b>                                 |  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3213 E. Fairmount St.</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Funk</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Truffer</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |   | 17. INFORMANT ADDRESS<br><b>21224 Mrs. Mildred Funk, 3213 E. Fairmount</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Pulmonary Infection</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Metastatic Lung Cancer</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 day</b><br><b>6 wks</b> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Thrombocytopenia, Urinary Tract Infection</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7 P.M. 10 6 1986</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY STATE<br><b>3213 E. Fairmount Balt MD</b>               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/6 June 86</b> to <b>10/6 86</b> , that (I) (we) last saw the deceased alive on <b>10/6/86</b> at <b>19 56</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Tara O'Toole</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>10/6/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TARA O'TOOLE</b>   |  | 22e. ADDRESS<br><b>2323 Orleans St. BALT. 21224</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>10/9/86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br><b>Joseph N. Zannino Jr. 21224</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed only 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2255

A.B.U

00-22517

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |   |  |  |
|---|--|---|--|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |   |   |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Chana Bona GAINES</b>  |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>October 28, 1986</b>  |   | 2b HOUR<br><b>5:27A<sub>M</sub></b>   |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Black</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>7 20 1915</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>  |   | 12b KIND OF BUSINESS OR OCCUPATION<br><b>Public Schools</b>  |  |
| 13a STATE<br><b>Maryland</b>  |  |   | 13b COUNTY   |  | 13c CITY OR TOWN<br><b>Baltimore</b>  |   | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Daniel V. Young</b>  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Millie A. Thomas</b> |  |   | 13e STREET ADDRESS / ZIP CODE<br><b>Baltimore, Md. 1618 N. Bentalou Street 21216</b>  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>  |  |   | 16b SOCIAL SECURITY NO.<br><b>225-22-5614</b>                        |  | 17 INFORMANT ADDRESS<br><b>Mr. Arlington, Virginia 22206 Dr. Joseph D. Alexander 2522 C South Walter Reed</b> |   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Possible Ventricular arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |   |   |   |  |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |   | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                                  |   |   |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)       |  | 21f LOCATION CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a I certify that (this hospital) attended the deceased from <b>September 16, 19 86</b> , to <b>October 28, 19 86</b> , that (I) (we) last saw the deceased alive on <b>October 28, 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |   |   |  |  |
| 22b SIGNATURE<br><b>Henry Nammour M.D.</b>  |  |   | DEGREE<br><b>M.D.</b>  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br><b>10-28-86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HENRY NAMMOUR</b>  |  |   | 22e ADDRESS<br><b>c/o Maryland General Hospital</b>                  |  |   |   |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b DATE<br><b>11/01/86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>   |   | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |
| 24 FUNERAL DIRECTOR'S NAME<br><b>NUTTER &amp; SONS FUNERAL HOME, INC.</b>   |  |   |  |  |   | 25a DATE RECEIVED BY REGISTRAR<br><b>OCT 29 1986</b>  |   | 25b REGISTRAR'S SIGNATURE  |  |
| 25c ADDRESS<br><b>2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216</b>  |  |   |  |  |   |   |   |  |  |

MEDICAL CERTIFICATION

29

BP





00-21502

STATE OF MARYLAND, DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28139

|  |  |                         |  |  |  |   |  |   |  |  |  |   |  |
|--|--|-------------------------|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HENRY</b>  |  | FIRST                   |  | MIDDLE   |  | LAST<br><b>A. (GAINS) GAINES, JR.</b>                           |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>10-17-86</b>  |  | MONTH DAY YEAR   |  | 2b. HOUR<br><b>12:50</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 28 51</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>34 YRS.</b>               |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br><b>10-17-86</b>                            |  | 2d. HOUR<br><b>12:50</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>          |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2101 Cliftwood Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1824 N. Bethel Street 21213</b>              |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry A. Gaines</b>   |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucille White</b>  |  |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |  |                         |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br><b>215-56-0176</b>                  |  | 17. INFORMANT ADDRESS<br><b>Linda Gaines 826 W. North Avenue Apt. A</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Narcotism and alcoholism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>nephrosclerosis</b>  |  |                         |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:15 P.M. 10 16 86</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Subject used drugs</b>  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>side entrance</b>  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2101 Cliftwood Ave. Balto., - Md.</b>   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |                         |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>10-17-86</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>10/21/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>March Funeral Homes 1101 East North Avenue</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1986</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORMS 1, 2, 3 AND 4. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MDHMH - 17  
(VR A15 ME (5))



00-21725

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8628140

|   |  |  |  |   |                           |  |  |
|---|--|--|--|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWIN NMN GAINOR</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/21/86</b> |   | 7b. HOUR<br><b>1410</b> M |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 17, 1905</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <b>80</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sec. Guard</b>   |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Amer. Stand.</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Arbutus</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Gainor</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Charlotte Dorsey</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |                           | 16b. SOCIAL SECURITY NO.<br><b>216-03-1151 A</b>   |  |
| 17. INFORMANT<br>ADDRESS<br><b>Viola Fitzgerald 606 Brisbane Ave. 21229</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Extensive Anterior Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hours</u><br><u>10 years</u>   |                           | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                           |  |  |
| 22b. SIGNATURE<br><u>Jeffrey F. Cole, M.D.</u><br>DEGREE  |  |  |  | 22c. DATE SIGNED  |                           | 22d. ADDRESS<br><u>3455 Wilkens Ave. 21229</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/24/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ambrose, Inc. 1328 Sulphur Sp. Rd. 21227</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR SIGNATURE<br><b>30122</b>  |                           |  |  |

MEDICAL CERTIFICATION

9/30/86

9/30/86

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

| NAME        | ADDRESS      | CITY   | STATE | COUNTY |
|-------------|--------------|--------|-------|--------|
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |
| J. M. Smith | 123 Main St. | Denver | CO    | ADAMS  |

0-22783

Item # 6,G-621.11.3.86.gbj.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES WILLIAM GALES   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 29, 1986                     |   | 2b. HOUR<br>4:52 PM                       |
| 3. SEX<br>MALE   | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 14 23  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62<br><del>65</del> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CHIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired |   | 12b. KIND OF BUSINESS OR INDUSTRY         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO.                                 |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIE STETSON GALES   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SALLY BRUNSON              |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                       |  | 16b. SOCIAL SECURITY NO.<br>?   |   | 17. INFORMANT<br>ADDRESS<br>CORA LEE GALES 1611 CHILTON ST. |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Myocardial Infarction &amp; Vent. Tachy.

DUE TO, OR AS A CONSEQUENCE OF

(b) ASCVD.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Chronic Renal Failure / Acute Renal Failure / metabolic acidosis.

|  |   |  |  |
|--|---|--|--|
| 19a. DATE OF OPERATION<br>Ø  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ø                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>Ø P.M. 19            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>Ø  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>OR WHILE <input type="checkbox"/> NOT AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)<br>Ø | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Ø                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 28</u> 19 <u>86</u> to <u>October 29</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>October 29</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE<br>Jeffrey A. Grass, M.D.   |   | 22c. DATE SIGNED<br>10/29/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeffrey A. GRASS, M.D.  |   | 22e. ADDRESS<br>Union Memorial Hospital.   |  |

|  |                      |   |   |
|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL | 23b. DATE<br>11-3-86 | 23c. NAME OF CEMETERY OR CREMATORY<br>KINGS MEMORIAL PARK | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RANDALLSTOWN MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>MARCH FUNERAL HOME     |                      | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1986              |   |
| ADDRESS<br>1101 E. NORTH AVE.                          |                      | 25b. REGISTRAR'S SIGNATURE                                |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

2-27-50

100% COTTON



MADE IN  
U.S.A.

X

100% COTTON

X

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| FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 28142  |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | Date of Death   |  |
| ELIZABETH H GALLAGHER   |  | ELIZABETH H GALLAGHER  |  | 10 22 86 1986 1110A M   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>10 18 07  |  |
| 6. BIRTHPLACE<br>Connecticut  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MARYLAND GENERAL HOSPITAL   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>School Teacher  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>A.A.  |  | 13c. STREET ADDRESS / ZIP CODE<br>101 Oakleigh Avenue 21061   |  |
| 14. FATHER'S NAME<br>Herbert H. Hartman   |  | 15. MOTHER'S MAIDEN NAME<br>Catherine Tipton   |  | 16. SOCIAL SECURITY NO.<br>214 24 2456  |  |
| 17. INFORMANT<br>Richard A Gallagher  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock 2° to pulmonary stenosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sepsis Suspected</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>chronic Renal failure</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/25/86 to 10/25/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br>Michael Yen   |  | 22c. DATE SIGNED<br>10/22/86   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Yen  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>10/25/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Park   |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Glen Burnie  |  | 23e. COUNTY<br>A.A.  |  | 23f. STATE<br>Md  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Raymond C. Fink   |  | 24b. ADDRESS<br>Glen Burnie, Md 21061  |  | 25. DATE REC'D. BY REGISTRAR<br>OCT 23 1986   |  |

00-31821

DE 10-11-07



RECEIVED



0-21258

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                     |  |
|---|--|--|--|--|--|---|--|-------------------------------------|--|
| 1- FOR STATE REGISTRAR  |  | 3 DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                            |  |
|   |  | THELMA E. GALLOWAY   |  |  |  | 10 13 86  |  | 234 P M                             |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. |  |
| FEMALE  |  | BLACK  |  | 8 25 26  |  | 58 YRS  |  | MONTHS DAYS HOURS MIN.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                     |  |
| NEW YORK  |  | U.S.A.   |  |  |  | BALTIMORE CITY MD.  |  |                                     |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (IF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                     |  |
| BALTO.  |  | SINAI HOSPITAL   |  | PATIENT TECHNICIAN   |  | BROOKLYN HOSPITAL   |  |                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE      |  |
| MARYLAND  |  |  |  | BALTIMORE  |  |   |  | BALTO. MD. 21207                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |                                     |  |
| EMERSON TURNER  |  | MABLE SPELLER  |  |  |  |   |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                                     |  |
| NO  |  | 074-22-1814  |  | BALTIMORE, MD. 21216   |  | APT A-5   |  |                                     |  |
|   |  |  |  | ROBERT L. GALLOWAY   |  | 3915 LIBERTY HGTS AVE   |  |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  |  | RESPIRATORY ARREST   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                     |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | SEVERE COPD  |  |   |  |                                     |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0  |  |  |  |  |  |   |  |                                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                     |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 10-13-86 to 10-13-86, that (1) (we) lost saw the deceased alive on 10-13-86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body of death. |  | 22b. SIGNATURE DEGREE  |  | 22c. DATE SIGNED   |  |   |  |                                     |  |
| PATRICIA SNELLO   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 10-13-86   |  |   |  |                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                                     |  |
| PATRICIA SNELLO   |  | SINAI HOSPITAL   |  |  |  |   |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                     |  |
| BURIAL  |  | 10/20/86   |  | GARRISON FOREST VETERANS   |  | BALTIMORE, MARYLAND   |  |                                     |  |
| 24. FUNERAL HOME NAME ADDRESS   |  | 25a. DATE REGD. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                     |  |
| NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216   |  | OCT 17 1986  |  |  |  |   |  |                                     |  |

BP

Handwritten notes and signatures, mostly illegible due to blurriness. Some legible fragments include:

- Top right: 02519-0
- Top center: *[Faint signature]*
- Middle left: *[Faint signature]*
- Middle center: *[Faint signature]*
- Bottom center: *[Faint signature]*
- Bottom right: *[Faint signature]*

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |  |   |  |  |  |
|---|--|---|---|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |   |  |  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>M. MADELINE GAMBRELL   |  |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 11, 1986     |   |  | 2b. HOUR<br>M  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 24, 1903   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Proprietor   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Candy Store   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |   |  |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>830 W. 40th St., 21211   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Albert Moore  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma Guise |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |   |  | 16b. SOCIAL SECURITY NO.<br>212 40 7013                  |   | 17 INFORMANT ADDRESS<br>Gordon A. Fisher, PA                 |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>912 IMMEDIATE CAUSE (a) <u>Aspiration with Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr   |  |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) this hospital attended the deceased from <u>Apr</u> 19 <u>86</u> to <u>10/11</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Richard I. Diamond</u>   |  |   |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Richard Diamond, MD  |  |   |   |  |  | 22e. ADDRESS<br>3547 Chestnut Ave., Balto. MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>10/16/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood           |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. County, MD |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 15 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These permits are required for the removal of the body from the place of death to the place of burial, cremation, or other final disposition. If item 21 is marked as "other than injury, or other traumatic event, medical examination not required," the funeral director may not be required to complete this section.

RELEASED AS NON-MED PER DR. KAUFFMAN &amp; MR. GREGORY, MEDICAL EXAMINER'S

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |                         |  |  |
|--|--|--|--|--|---|--|-------------------------|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |   |  |                         |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BABY BOY George A. GARAMI</b>  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 8, 1986</b>         |  | 2b. HOUR <b>9:16 MP</b> |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 29 1986</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>10</b>   |                         | IF UNDER 1 YEAR MONTHS <b>10</b> IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |                         |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-----</b>                   |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Howard</b>  |  | 13c. CITY OR TOWN <b>Ellicott</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         | 13e. STREET ADDRESS / ZIP CODE <b>4345 Wild Filly Ct. 21043</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>George A. Schwartz</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carol Garrani</b> |  |                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS <b>George A. Schwartz 4345 Wild Filly Ct. 21043</b>  |   |  |                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>   |  |  |  |  |   |  |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MINUTES</b>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>PERSISTENT PULMONARY HYPERTENSION</b>   |  |  |  |  |   |  |                         | 7 DAYS   |  |
| (c)  |  |  |  |  |   |  |                         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |                         |  |  |
| 19a. DATE OF OPERATION <b>9/30/86</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>OMPHALOCOELE, IMPERFORATE ANUS</b>   |  |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                         |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                         |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/30/86</b> , 19 <b>86</b> , to <b>10/8</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/8</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |                         |  |  |
| 22b. SIGNATURE <b>Peter M. Haney</b>   |  | DEGREE <b>M.D. Ph.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   |  |                         | 22c. DATE SIGNED <b>10/9/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER M. HANEY</b>  |  |  |  | 22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL BALTIMORE 21205</b>   |   |  |                         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>10-11-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ellicott City Howard Md.</b>                      |                         |  |  |
| 24. FUNERAL DIRECTOR <b>Harry H. Witzke &amp; Family Funeral Home</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 10 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE   |                         |  |  |
| 4112 Columbia Pike   |  |  |  |  |   |  |                         |  |  |

George A.

Male Caucasian Sept. 19 1900 10

Maryland United States

Maryland Howard Illinois x 4345 WILD PAIRY CO. 11043

George A. Schwarze A. Schwarze

George A. Schwarze 4345 WILD PAIRY CO.



10-11-44  
Barry H. Hinkle & Family Funeral Home  
11041  
Howard City Howard 101

00-21819

Item# G 620 10/29/86 CW

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8

1 4 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ERNEST H GARCIA   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 17, 1986      |  |  | 2b. HOUR<br>P<br>3:15 <sup>P</sup> <sub>M</sub>   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>SPANISH  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 19 1915   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Honduras<br>Central America   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chef Cook                   |  |
| 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Hospital<br>Union Memorial   |  |   |  |  |  |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br>3011 Poplar Terrace, Baltimore, Md. 21216  |  |   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Pablo Garcia   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Justa Gatoy |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No.  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-14-4028  |  | 17. INFORMANT<br>Mrs. 3011 Poplar Terrace<br>Hettie M. Garcia Baltimore, Md. 21216   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepatic failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic adenocarcinoma of colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 month<br>20 months   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>86</u> , to <u>10/17</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I did) (did not) view the body after death.                      |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Scott Touger MD</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>10/17/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Scott Touger MD   |  |   |  | 22e. ADDRESS<br>600 N. Wolfe 21205   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/23/1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Nutter & Sons Funeral Home, Inc.<br>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216   |  |   |  | 25a. DATE REG. BY REGISTRAR<br>OCT 23 1986   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The local requires the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in envelope and place in box with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-51813

General  
Investigation

Overlook

Warrant

Harvard

Review

Topic

1930-1935

ON

FILE

1935-1936



00-21109

Item # 2a, &amp; 2b, Film G620, 10.29.86 ra

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

23147

REG. NO.

|  |  |  |  |   |                               |  |  |
|--|--|--|--|---|-------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>AARON W. GARNETT  |  |  | 2a. DATE OF DEATH<br>MONTH 10 DAY 10 YEAR 86 |   | 2b. HOUR OF DEATH<br>12:20 AM |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH 2 DAY 12 YEAR 34  |                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Deaton Hospital + med. center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Disabled  |                               | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Granville Aaron Garnett  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Tunstall   |  | 13e. STREET ADDRESS / ZIP CODE<br>528 N. Calhoun Street 21223   |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>218-30-6755  |  | 17. INFORMANT<br>Doris Patterson  |                               | ADDRESS<br>1552 Moreland Ave   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Squamous cell carcinoma of the tongue<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |                               |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)  |                               |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 9 1986, to Oct 10 1986, that (I) (we) lost saw the deceased alive on Oct 9 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |   |                               |  |  |
| 22b. SIGNATURE<br>George Taler, M.D.   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                               | 22c. DATE SIGNED<br>Oct 10, 1986   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George Taler, M.D.  |  | 22e. ADDRESS<br>600 Light St. Balt. Md. 21230  |  |   |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/14/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem Park  |                               | 23d. LOCATION<br>Arbutus COUNTY MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Home West 4300 Wabash Avenue   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 15 1986  |                               | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of a death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Thereafter, the certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If both 21 and 22 are marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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14

4442

1000

100% COTTON FIBER

100% COTTON FIBER

00-20119

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |   |  |  | REG. NO. 86 28148   |                                |                                   |  |
|--|--|---|--|--|--|--|---|--|--|---|--------------------------------|-----------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR           |  |   |  |  |   |                                | 2b. HOUR                          |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR           |  |   |  |  |   |                                | 2b. HOUR                          |  |
| ESTELLA MARIE GARRITY  |  |   |  |  | 10 04 86                                   |  |   |  |  |   |                                | 5:44 P M                          |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN.  |                                |                                   |  |
| FEMALE   |  | CAUCASIAN   |  | 03 13 1897   |  | 89 YRS.  |   |  |  |   |                                |                                   |  |
| 7a. BIRTHPLACE (COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |   |                                |                                   |  |
| MARYLAND   |  | USA   |  |  |  | Balto. City MD.  |   |  |  |   |                                |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore  |  | Liberty Med. Center   |  |  |  |  |   |  |  | Housewife   |                                | Homemaker                         |  |
| 13a. STATE   |  |   |  |  | 13b. COUNTY                                |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE |                                   |  |
| Md   |  |   |  |  |  |  | Balto.  |  | YES  |   | 4700 Hartford Rd 21214         |                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |  |   |  |  |   |                                |                                   |  |
| WILLIAM A. BROWN   |  |   |  |  | BETTY LAVENIA HARTZEL                      |  |   |  |  |   |                                |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  |  | 16b. SOCIAL SECURITY NO.                   |  | 17. INFORMANT ADDRESS   |  |  |   |                                |                                   |  |
| NO   |  |   |  |  | 219-01-1915                                |  | Tansdowne, Maryland 21227<br>Scott H. Garrity Jr 320 Wisewell Ct. |  |  |   |                                |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                |                                   |  |
| IMMEDIATE CAUSE (a) Cardiorespiratory Arrest   |  |   |  |  |  |  |   |  |  |   |                                |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |   |  |  |  |  |   |  |  |   |                                |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |  |  |  |   |  |  |   |                                |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |  |  |   |  |  |   |                                |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |  |  |   |  |  |   |                                |                                   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |   |  |  |   |                                |                                   |  |
|  |  |   |  | P.M. 19  |  |  |   |  |  |   |                                |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |   |                                |                                   |  |
|  |  |   |  |  |  |  |   |  |  |   |                                |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31/86 to 10/4/86, that (I) (we) last saw the deceased alive on 10/4/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If the (I) (did) did not view the body after death. |  |   |  |  |  |  |   |  |  |   |                                |                                   |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  |  |   | 22c. DATE SIGNED   |  |   |                                |                                   |  |
| Jorge F. Gonzalez, M.D.  |  |   |  | M.D.   |  |  |   | 10/4/86  |  |   |                                |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |   |  |  |   |                                |                                   |  |
| Jorge F. Gonzalez, M.D.  |  |   |  | Liberty Med. Center  |  |  |   |  |  |   |                                |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPELLED)  |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                                |  |   |                                |                                   |  |
| BURIAL   |  |   |  | 10/7/86  |  | Glen Haven Park  |   | Glen Burnie A A Md   |  |   |                                |                                   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |   |  |  |   |                                |                                   |  |
| Raymond C. Fink Glen Burnie, Md. 21061   |  |   |  |  |  | OCT 06 1986  |   |  |  |   |                                |                                   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28149

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Howard A. Gearhart |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-11-86   |  | 2b. HOUR<br>2:45 AM  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-24-07  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Liberty Medical Center |   | 12a. USUAL OCCUPATION<br>(GIVE WORK FOR MOST OF WORKING LIFE)<br>Steelworker                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth Steel              |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7822 St. Gregory Dr. 21222 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Gearhart                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clara Owens  |   | ADDRESS 7822 St. Gregory Dr.                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No     |   | 16b. SOCIAL SECURITY NO.<br>213-09-0507   |   | 17. INFORMANT<br>Mrs. Lilia Gearhart                       |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>winary tract infections</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD.

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE FARM ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-2-86</u> to <u>10-11-86</u> , that (I) (we) last saw the deceased alive on <u>10-10-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>A. Matthew</u>   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>10-11-86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. Matthew   | 22e. ADDRESS<br>Liberty Medical Center 730 Ashblum Baltimore   |  |   |

|  |                       |  |  |
|--|-----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL | 23b. DATE<br>10/13/86 | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph N. Lannino Jr.  |                       | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986           | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                        |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked on Item 18 shows any injury, or other traumatic event, all medical records should be obtained at once.

MEDICAL CERTIFICATION

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY C. ANN GEARHART</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>9</b> YEAR <b>86</b>  |  | 2b. HOUR<br><b>8-00 PM</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>25</b> YEAR <b>02</b>                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. ANNE'S HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>EUGENE</b> MIDDLE <b>EDWARD</b> LAST <b>FAGAN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ROSE</b> MIDDLE <b>ANNA</b> LAST <b>FRANCE</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>    |  |
| 16b. SOCIAL SECURITY NO.<br><b>219-34-4834</b>   |  | 17. INFORMANT<br><b>STANLEY GEARHART</b>  |  | ADDRESS<br><b>9149 E. STAYMAN DR.<br/>ELLICOTT CITY, MD 21043</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>UTI, sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Latha R Pillai</b>  |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. LATHA PILLAI</b>   |  |   |  | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>13 OCT 86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GOOD SHEPHERD CEM.</b>                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SLACK FUNERAL HOME</b>  |  | ADDRESS<br><b>Box 263<br/>ELLICOTT CITY, MD 21043</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>                                  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and place them in the envelope provided. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be called to the scene.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 80 28151<br>REG. NO.   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SISTER MARY JOHN GERRITY, OSF  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-24-86  |   |  | 2b. HOUR<br>7:35 A.M.                                     |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 21, 1901  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Union Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Religious Order |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Order of St. Francis |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |  |  |   | 13b. COUNTY<br>Balto.  |   | 13c. STREET ADDRESS / ZIP CODE<br>3725 Ellerslie Ave., 21218   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael Joseph Gerrity  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Cecilia Higgins   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220 54 9345   |  | 17. INFORMANT<br>ADDRESS<br>Sr. Rita Mary, Same   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ELECTROMECHANICAL DISSOCIATION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GLOBAL LEFT VENTRICULAR DYSFUNCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCVD, MI, IBDM, chronic renal failure, dementia</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>D.M., renal failure, dementia</u> |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>N/A   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>N/A   |  |   |  |   |  |
| 21d. INJURY OCCURRED N/A<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>N/A  |  | 21f. LOCATION<br>CITY OR TOWN STREET COUNTY STATE<br>N/A  |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>86</u> , to <u>10/24</u> , 19 <u>86</u> , that (1) (two) last saw the deceased alive on <u>10/23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Jean K. Janda, M.D.   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>10/24/86                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jean Janda, M.D.   |  |  |  |   | 22e. ADDRESS<br>The Union Memorial Hospital  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10/28/86  |  | 23c. NAME OF CEMETERY<br>St. Elizabeth's  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1986   |   | 25b. REGISTRAR'S SIGNATURE   |   |  |

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State of New York

Michael Joseph Corbin

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |                                  |  |  |
|---|--|---|--|---|---|---|----------------------------------|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |   |   |                                  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RICHARD GILBERT</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 2, 1986</b>           |   | 2b. HOUR<br>P M<br><b>5:35 P</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 25 18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |                                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corporation</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>              |                                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  | 13e. STREET ADDRESS / ZIP CODE<br><b>3 St. Paul Street, 21202</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Gilbert</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown Unknown</b> |   |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-14-3106</b>  |  | 17. INFORMANT ADDRESS<br><b>Del Summers, 8136 Main Street, Ellicott City</b>  |   |   |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>CANCER OF THE PANCREAS</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |                                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18   |  |   |  |   |   |   |                                  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |                                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 23 86</b> , to <b>OCTOBER 2 86</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 2 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |  |   |   |   |                                  |  |  |
| 22b. SIGNATURE<br><b>B Nagpal</b>   |  |   |  | DEGREE  |   |   |                                  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEENA NAGPAL MD.</b>  |  |   |  | 22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION<br/>100 NORTH BROADWAY BALTIMORE, MD. 2123</b>  |   |   |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/9/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Maryland</b>                |                                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc., 4107 Wilkens Ave. 21229</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 06 1986</b>   |   |   |                                  |  |  |



00-20099

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this permit to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other terminal condition, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28153

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  | 20. DATE OF DEATH   |   | 26. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 20. DATE OF DEATH   |   | 26. HOUR  |  |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR  |   | 245 PM  |  |
| Rubye C. Gill   |  | 10 3 86   |   | 245 PM  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR   |  |
| F   | B  | MONTH DAY YEAR  | 74 YRS  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |
| Mississippi   | USA  |   | Baltimore City MD.  |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Balto, Md.  | Mary Hospital  |   | Teacher   |   |  |
| 13a. STATE  |  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13e. STREET ADDRESS / ZIP CODE  |  |
| Md.   |  |   | Balto   | 3415 Callaway Ave 21215   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |   |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |   |   |  |
| John Arthur Harris  |  | Lorraine Johnson  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |  |
| No  |  | 294-22-9018   |   | Mrs. Roberta Gill 3415 Callaway   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c).   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Cardiopulmonary arrest  |  |   |   |   | 35 minutes                                   |
| Possible pulmonary embolism   |  |   |   |   |  |
| Coronary of colon with extensive liver metastases   |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |  |
| 3 days after abdominal surgery  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?   |  |
| 9/30/86   |  | Carcinoma Colon   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) |  |
|   |  | P.M. 19   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                  |  |
|   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE DEGREE   |  |   |   | 22c. DATE SIGNED  |  |
| Lewis S. Dingle, M.D.   |  |   |   | 10/3/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   | 22e. ADDRESS  |  |
| Lewis S. Dingle, M.D.   |  |   |   | 3502 W. Rogers Ave. Suite #3 Balto. Md. 21215                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 10-10-86  |   | Woodlawn Cem.   |  |
|   |  |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
|   |  |   |   | Balto Md.   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                        |  |
| James A. Morton & Sons 1701 Laurens St.   |  |   |   | OCT 06 1986 [Signature]   |  |



Howe

6M

10-12-50

10-12-50

10-12-50

00-22042

 Items, 18a, 222a, 11/5/86  
 FOR STATE Med.Ex., G-621  
 REGISTRAR Gbj.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 28154  
 REG. NO.

|  |                         |  |  |   |   |
|--|-------------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM E. GILLEY</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>10 19 86</b> |   | 2b. HOUR<br>M<br><b>9:10 A</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/17/1947</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>39</b>   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>10 19 86</b>                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1203 Durst St. Balto. Md. 21230</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>-----</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><b>21230 1203 Durst St. Balto. Md.</b>                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles E. Gilley</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marion ---- Collison</b>                               |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>212-48-2251</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Marion Whitney, Same as above</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Tracheobronchitis with bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>and ethanol intoxication.</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                 |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |  |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                              |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |  |   |   |
| ACTUAL SIGNATURE<br><b>Charles P. Kokes</b>  |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |  | DATE SIGNED <b>10-20-86</b>   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Charles P. Kokes, M.D.</b>  |                         | ADDRESS <b>111 Penn St., Balto., MD 21201</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |                         | 23b. DATE<br><b>10/22/86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process Crem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Balto. Co. Md.</b>    |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Balto. Md. 21230</b><br><b>McCully Funeral Home, 130 E. Fort Ave.</b>   |                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP 342  
 DHMH - 17  
 (VR A15 ME (5))



UNIVERSITY OF CALIFORNIA

LIBRARY



0-20284

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>NANCY RICHARDSON GILYARD</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 04 86</b>                 |   |  | 2b. HOUR<br><b>8:14 P</b>  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 16 1915</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Liberty Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEAMSTRESS</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMPLOYED TAILOR SHOP</b>  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>2518 CALVERTON HTS. AVE. BALTIMORE, MD. 21216</b>  |  |  |  | 13f. STREET ADDRESS / ZIP CODE<br><b>2518 CALVERTON HTS. AVE. BALTIMORE, MD. 21216</b>  |  | 13g. STREET ADDRESS / ZIP CODE<br><b>2518 CALVERTON HTS. AVE. BALTIMORE, MD. 21216</b>   |  | 13h. STREET ADDRESS / ZIP CODE<br><b>2518 CALVERTON HTS. AVE. BALTIMORE, MD. 21216</b>                                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JIMMIE RICHARDSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BERTHA JACKSON</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO.</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-22-8576</b>   |  | 17. INFORMANT<br><b>MARTHA R. MOTON BALTIMORE, MD. 21216</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10/4/86</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/4/86</b> , 19 <b>86</b> , to <b>10/4</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/4</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>George F. Gonskyler, M.D.</b>  |  |  | 22c. DEGREE<br><b>M.D.</b>   |   |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22e. DATE SIGNED<br><b>10/4/86</b>                                       |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George F. Gonskyler, M.D.</b>   |  |  | 22g. ADDRESS<br><b>Liberty Med. Center</b>                             |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>10/10/1986</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEMETERY</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b> |  |
| 24. FUNERAL HOME OR SONS FUNERAL HOME, INC.<br>2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 08 1986</b>  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |  |  |  |  |

BP

10302-

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |
|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELEANOR BOWERSOX GLEASON</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 14, 1986</b> |   |   | 2b. HOUR<br><b>3P<sup>M</sup></b>                                |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 8, 1908</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green N.H.</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b> |  |

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13b. STATE Maryland 13c. COUNTY Baltimore 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 1108 Ramblewood Road 21239

|  |  |
|--|--|
| 14. FATHER'S NAME                            | 15. MOTHER'S MAIDEN NAME                 |
| FIRST MIDDLE LAST<br>William Albert Bowersox | FIRST MIDDLE LAST<br>Josephine O'Donnell |

|   |  |                 |                         |
|---|--|-----------------|-------------------------|
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) | 17 INFORMANT    | ADDRESS                 |
| No  | 212-07-8950  | Ms. G.M.Gleason | 6647 Walther Ave. 21206 |

|   |                                     |   |
|---|-------------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |                                     |   |
| IMMEDIATE CAUSE (a)   | Cardiovascular collapse             | 2 hr  |
| DUE TO, OR AS A CONSEQUENCE OF  |                                     |   |
| (b)   | Bilateral severe CVA -              | 10 yr + 6 mo                                    |
| DUE TO, OR AS A CONSEQUENCE OF  |                                     |   |
| (c)   | Atherosclerotic heart disease + CAB | 15 yr   |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 5

|                       |   |   |   |
|-----------------------|---|---|---|
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|-----------------------|---|---|---|

|   |  |  |
|---|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|--|--|

|         |   |  |               |              |              |
|---------|---|--|---------------|--------------|--------------|
| MEDICAL | 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION |              |              |
|         | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> |  | STREET        | CITY OR TOWN | COUNTY STATE |

22a I certify that (I) (this hospital) attended the deceased from 2/10, 1982, to 10/14, 1986, that (I) ~~(we)~~ last saw the deceased alive on 10/14, 1986, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(do not)~~ view the body after death.

|  |  |  |                              |
|--|--|--|------------------------------|
| 27b. SIGNATURE<br><i>Norman R. Freeman Jr.</i>                 | DEGREE<br>M.D.                         | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 27c. DATE SIGNED<br>10/15/86 |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Norman R. Freeman Jr. | 27e. ADDRESS<br>4300 North Charles St. |  |                              |

|   |                              |  |   |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>10-16-86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b> | 23d. LOCATION<br>CITY OR TOWN<br><b>Balto. City</b><br>COUNTY<br><b>Maryla</b><br>STATE |
|---|------------------------------|--|---|

|  |   |
|--|---|
| <p>24 FUNERAL DIRECTOR</p> <p>NAME ADDRESS</p> <p>Mitchell-Wiedefeld Home 6500 York Road 21212</p> | <p>25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE</p> <p>OCT 17 1986</p> |
|--|---|

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

BP.

1751

1515 1530 1545 1560 1575 1590 1605 1620 1635 1650 1665 1680 1695 1710 1725 1740 1755 1770 1785 1800 1815 1830 1845 1860 1875 1890 1905 1920 1935 1950 1965 1980 1995 2010 2025 2040 2055 2070 2085 2100 2115 2130 2145 2160 2175 2190 2205 2220 2235 2250 2265 2280 2295 2310 2325 2340 2355 2370 2385 2400 2415 2430 2445 2460 2475 2490 2505 2520 2535 2550 2565 2580 2595 2610 2625 2640 2655 2670 2685 2700 2715 2730 2745 2760 2775 2790 2805 2820 2835 2850 2865 2880 2895 2910 2925 2940 2955 2970 2985 3000 3015 3030 3045 3060 3075 3090 3105 3120 3135 3150 3165 3180 3195 3210 3225 3240 3255 3270 3285 3300 3315 3330 3345 3360 3375 3390 3405 3420 3435 3450 3465 3480 3495 3510 3525 3540 3555 3570 3585 3600 3615 3630 3645 3660 3675 3690 3705 3720 3735 3750 3765 3780 3795 3810 3825 3840 3855 3870 3885 3900 3915 3930 3945 3960 3975 3990 4005 4020 4035 4050 4065 4080 4095 4110 4125 4140 4155 4170 4185 4200 4215 4230 4245 4260 4275 4290 4305 4320 4335 4350 4365 4380 4395 4410 4425 4440 4455 4470 4485 4500 4515 4530 4545 4560 4575 4590 4605 4620 4635 4650 4665 4680 4695 4710 4725 4740 4755 4770 4785 4800 4815 4830 4845 4860 4875 4890 4905 4920 4935 4950 4965 4980 4995 5010 5025 5040 5055 5070 5085 5100 5115 5130 5145 5160 5175 5190 5205 5220 5235 5250 5265 5280 5295 5310 5325 5340 5355 5370 5385 5400 5415 5430 5445 5460 5475 5490 5505 5520 5535 5550 5565 5580 5595 5610 5625 5640 5655 5670 5685 5700 5715 5730 5745 5760 5775 5790 5805 5820 5835 5850 5865 5880 5895 5910 5925 5940 5955 5970 5985 6000 6015 6030 6045 6060 6075 6090 6105 6120 6135 6150 6165 6180 6195 6210 6225 6240 6255 6270 6285 6300 6315 6330 6345 6360 6375 6390 6405 6420 6435 6450 6465 6480 6495 6510 6525 6540 6555 6570 6585 6600 6615 6630 6645 6660 6675 6690 6705 6720 6735 6750 6765 6780 6795 6810 6825 6840 6855 6870 6885 6900 6915 6930 6945 6960 6975 6990 7005 7020 7035 7050 7065 7080 7095 7110 7125 7140 7155 7170 7185 7200 7215 7230 7245 7260 7275 7290 7305 7320 7335 7350 7365 7380 7395 7410 7425 7440 7455 7470 7485 7500 7515 7530 7545 7560 7575 7590 7605 7620 7635 7650 7665 7680 7695 7710 7725 7740 7755 7770 7785 7800 7815 7830 7845 7860 7875 7890 7905 7920 7935 7950 7965 7980 7995 8010 8025 8040 8055 8070 8085 8100 8115 8130 8145 8160 8175 8190 8205 8220 8235 8250 8265 8280 8295 8310 8325 8340 8355 8370 8385 8400 8415 8430 8445 8460 8475 8490 8505 8520 8535 8550 8565 8580 8595 8610 8625 8640 8655 8670 8685 8700 8715 8730 8745 8760 8775 8790 8805 8820 8835 8850 8865 8880 8895 8910 8925 8940 8955 8970 8985 9000 9015 9030 9045 9060 9075 9090 9105 9120 9135 9150 9165 9180 9195 9210 9225 9240 9255 9270 9285 9300 9315 9330 9345 9360 9375 9390 9405 9420 9435 9450 9465 9480 9495 9510 9525 9540 9555 9570 9585 9600 9615 9630 9645 9660 9675 9690 9705 9720 9735 9750 9765 9780 9795 9810 9825 9840 9855 9870 9885 9900 9915 9930 9945 9960 9975 9990 10005 10020 10035 10050 10065 10080 10095 10110 10125 10140 10155 10170 10185 10200 10215 10230 10245 10260 10275 10290 10305 10320 10335 10350 10365 10380 10395 10410 10425 10440 10455 10470 10485 10500 10515 10530 10545 10560 10575 10590 10605 10620 10635 10650 10665 10680 10695 10710 10725 10740 10755 10770 10785 10800 10815 10830 10845 10860 10875 10890 10905 10920 10935 10950 10965 10980 10995 11010 11025 11040 11055 11070 11085 11100 11115 11130 11145 11160 11175 11190 11205 11220 11235 11250 11265 11280 11295 11310 11325 11340 11355 11370 11385 11400 11415 11430 11445 11460 11475 11490 11505 11520 11535 11550 11565 11580 11595 11610 11625 11640 11655 11670 11685 11700 11715 11730 11745 11760 11775 11790 11805 11820 11835 11850 11865 11880 11895 11910 11925 11940 11955 11970 11985 12000 12015 12030 12045 12060 12075 12090 12105 12120 12135 12150 12165 12180 12195 12210 12225 12240 12255 12270 12285 12300 12315 12330 12345 12360 12375 12390 12405 12420 12435 12450 12465 12480 12495 12510 12525 12540 12555 12570 12585 12600 12615 12630 12645 12660 12675 12690 12705 12720 12735 12750 12765 12780 12795 12810 12825 12840 12855 12870 12885 12900 12915 12930 12945 12960 12975 12990 13005 13020 13035 13050 13065 13080 13095 13110 13125 13140 1315

00-21429

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

28157

REG. NO.

|   |  |  |   |   |  |  |
|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Daniel Glee</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 14 86</b>  |   | 2b. HOUR<br><b>539p.m.</b>   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 16 20</b>   |  |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN<br><b>V. H.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A</b>                          |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hosp.</b> |   |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. CITY OR TOWN<br><b>Balt</b>  |   | 13c. STREET ADDRESS / ZIP CODE<br><b>1514 Brentwood Ave. 21202</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>W. V. FORD</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline FORD</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218 070923</b>                          |   | 17. INFORMANT<br><b>Lucille Glee</b>  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Meningitis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Dennis Kurgan</b>  |  |  |   | 22c. DATE SIGNED<br><b>10-14-86</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dennis Kurgan</b>   |  |  |   | 22e. ADDRESS<br><b>301 St Paul Place Balt 21202</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>  |  | 23b. DATE<br><b>10-20-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FOREST</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MARCH FUNERAL HOMES</b>  |  | ADDRESS<br><b>1101 E. NORTH AVE.</b>                                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>OWINGS MILLS MD</b>  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1986</b>   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of once.

BP



00-21207

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove, for page 4, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, a coronial inquest must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH GLICK</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 10, 1986</b>                                 |   |  | 7b. HOUR<br><b>9:27M</b>   |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 15, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAINT. SUPERVISOR</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>3016 F ROMARIC CT. ( 21209)</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JULIUS G LICK</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BECKY KLEIN</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-2144</b>   |  | 17. INFORMANT ADDRESS<br><b>MRS. FLORENCE GLICK 3016 F ROMARIC CT. (21209)</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 seconds</b><br><b>8 days</b> |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                     |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/9</b> 19 <b>86</b> to <b>10/10</b> 19 <b>86</b> that (I) (we) (lost) saw the deceased alive on <b>10/10</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Lucy R Sutphin</b>   |  |  | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/10/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lucy R Sutphin</b>  |  |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO., MD</b><br><b>Johns Hopkins Hospital, Baltimore</b> |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>10/12/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORBAND CEM</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE, BALTO., MD.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT. 16 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John L. Davidson-Randall</b>   |  |

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00-22405

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James R. Glowacki   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 27 86                                |  | 2b. HOUR<br>8:40 P.M.  |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 04 01  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>- -  | IF UNDER 72 HRS<br>HOURS MIN.<br>- -   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balt. MD  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE IN SUCH FACILITY, FIVE STREET ADDRESS)<br>Francis & Jay Med Ctr |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>dye-maker  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Can Company                                     |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stanley Glowacki   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO<br>215-033-743  | 17. INFORMANT ADDRESS<br>Raymond Glowacki 6411 Golden Ring Rd.                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) CHF, COPD, Prosthetic CA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 2, 19 86, to 10/27, 19 86, that (I) (we) last saw the deceased alive on 10/27, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                                    |  |   |  |  |  |
| 22b. SIGNATURE<br>Michael R. Clark MD  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>10/27/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael R. Clark  |  | 22e. ADDRESS<br>4940 Eastern Ave Balt. MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10-31-86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Roary Cemetery                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Weber & Sons Inc.  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1986                                   |  | 25b. REGISTRAR'S SIGNATURE   |
| ADDRESS<br>401 S. Chester St.  |  |   |  |  |  |

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00188

00-2100

Francis

San Antonio, Texas

101 N. Green Avenue, El Paso

Executive

W. J. ...

... ..

... ..

20% COTTON

101 N. Green Avenue

San Antonio, Texas

W. J. ...

44  
00-224821- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>DR. ALFRED GOLBORO   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 26, 1986                   |   |  | 2b. HOUR<br>10 P.M.  |   |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>DEC, 30, 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6503 PARK HEIGHTS AVE. #2A (21215) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DENTIST  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>DENTISTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>(21215)<br>6503 PARK HEIGHTS AVE. #2A  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>SOLOMON  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CELIA SCHREIBER   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>213-38-5938A  |  | 17. INFORMANT ADDRESS<br>MRS. EDITH GOLBORO APT. 2A (21215)<br>6503 PARK HEIGHTS AVE.  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Resp. Failure assoc</u><br><u>to arteriosclerosis ht. dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr</u><br><u>3 m</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>"Causes of the face" Parkinsonism, brain atrophy</u>   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8/30</u> 19 <u>79</u> to <u>Oct 26 1986</u> , that (I) (we) lost<br>saw the deceased alive on <u>Oct 25</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Jonas Cohen</u><br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JONAS COHEN  |  |   |  |   |  | DEGREE<br>M.D. - ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>- PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>10/27/86   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>10/27/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>OHEB SHALOM MEM PARK |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>REISTERSTOWN, BALTO., MD. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTO., MD. (21215)  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1986   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper and file in the funeral director's office. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the funeral director must be notified at once.

BP

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00-21060

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 86 28162

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph</b>   |  | FIRST MIDDLE LAST <b>Goldberg</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>10 4 86</b>  |  | 2b. HOUR <b>1255P</b>   |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 15 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City, BALTO.</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Singer Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CHEMICAL OPERATOR</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>CHEMICALS</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY <b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>AARON GOLDBERG</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>FREDA LABOWITZ</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>212-01-9334</b>   |  |
| 17. INFORMANT<br><b>MRS. MIRIAM GOLDBERG</b>  |  | 17. ADDRESS <b>1 Greenbury Ct. BALTO. MD</b>   |  | 17. APT. <b>F</b>   |  | 17. ZIP CODE <b>#21207</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pump Failure and Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hepatic and Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Heart Failure</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>0</b> |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-5</b> 19 <b>86</b> , to <b>10-4</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>10-3</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Stephen C Springate MD</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>10-4-86</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen C Springate</b>   |  |
| 22e. ADDRESS<br><b>Singer Hosp - Baltimore MD</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |   |  |   |  |
| 23b. DATE <b>OCT. 7, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>FORBAND</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1986</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |   |  |

BP

8-28167

1931-1932

SECTION NO. 1





00-20260

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28163

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Morris</i> FIRST <i>MORRIS</i> MIDDLE LAST <i>GOLDENBERG</i>  |   |   | 2a. DATE OF DEATH MONTH <i>10</i> DAY <i>1</i> YEAR <i>86</i>                  |  | 2b. HOUR <i>3:20A</i> M   |
| 3 SEX <i>MALE</i>  | 4. RACE <i>WHITE</i>  | 5. DATE OF BIRTH MONTH <i>7</i> DAY <i>6</i> YEAR <i>1900</i>   | 6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS                                  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.                 |  |   |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Loch Raven VA Medical Ctr</i> |   | 12. KIND OF BUSINESS OR INDUSTRY <i>SEWING MACHINE OPERATOR</i>                |  | 13. KIND OF BUSINESS OR INDUSTRY <i>CLOTHING</i>  |
| 13a. STATE <i>Maryland</i>   |   | 13b. COUNTY   | 13c. CITY OR TOWN <i>Baltimore</i>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <i>4554 Derby Manor Rd. #21215</i>   |
| 14. FATHER'S NAME FIRST <i>WOLF</i> MIDDLE <i>GOLDENBERG</i> LAST  |   | 15. MOTHER'S MAIDEN NAME FIRST <i>DORA</i> MIDDLE <i>BLUTRACH</i> LAST  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>   |   | 16b. SOCIAL SECURITY NO. <i>214-10-2881</i>   |  | 17. INFORMANT <i>MRS. VERA GOLDENBERG</i><br><i>4559 DERBY MANOR DR. BALTO., MD 21215</i>    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal Failure</i> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>36 hours</i><br><i>prior to Admission</i><br><i>underlying since Admission</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Portable Cancer of Lung</i>  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/24</i> 19 <i>86</i> , to <i>10/1</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>10/1</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If (we) did (it) not view the body after death).                                |   |   |  |  |   |
| 22b. SIGNATURE <i>Rodger A Blake MD</i>  |   | DEGREE  |  | 22c. DATE SIGNED <i>10/1/86</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rodger Alan Blake MD</i>  |   | 22e. ADDRESS <i>22 S. Greene St., Balto., MD 21201</i>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>  | 23b. DATE <i>OCT. 6, 1986</i>   | 23c. NAME OF CEMETERY OR CREMATORY <i>GARRISON FOREST VETERANS</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>OWINGS MILLS, BALTO., MD</i>                      |   |
| 24. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., INC.</i>   |   | 25a. DATE REG'D. BY REGISTRAR <i>06/08/1986</i>   |  | 25b. REGISTRAR'S SIGNATURE   |   |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |   |   |  |  |   |

88 58183

00-52500

*[Faint, illegible handwritten text and markings are visible across the page, including what appears to be a signature and various scribbles.]*

00-21209

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28164

REG. NO.

|  |  |  |  |
|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LAST</b> <b>GOLDSTEIN</b> <b>MIDDLE</b> <b>FIRST</b> <b>ROSE</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>OCT. 11 1986</b> 2b. HOUR <b>6:22 A M</b>  |  |
| 3. SEX <b>FEMALE</b>   | 4. RACE <b>CAUCASIAN</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 10 1912</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) <b>POLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVIN JAVIE HEBRON GERIATRIC CENTER + HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>                         |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MARYLAND</b> COUNTY <b>BALTO.</b> CITY OR TOWN <b>BALTIMORE</b>  | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13c. STREET ADDRESS / ZIP CODE <b>703 SEVEN MILE LANE 21208</b>  |  |
| 14. FATHER'S NAME FIRST <b>BENJAMIN</b> MIDDLE <b>JAPKO</b> LAST <b>JAPKO</b>  | 15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>SCHWARTZBERG</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  | 16b. SOCIAL SECURITY NO. <b>219-10-6254</b>  | 17. INFORMANT ADDRESS <b>ALBERT JAPKO 7503 SEVEN MILE LA ( 21208)</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC LUNG CA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |  |  |
| 19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. 19 _____ 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) _____   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____ 21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/31</b> , 19 <b>86</b> , to <b>10/11</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |  |  |
| 22b. SIGNATURE <b>E. O. KUN</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED <b>10/11/86</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELLITA O. KUN</b> 22e. ADDRESS <b>LEVIN JAVIE HEBRON GERIATRIC CENTER + HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  | 23b. DATE <b>10/12/86</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON CEM.</b>   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD.</b>  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b> 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 16 1986</b>   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

46182 48

00-51500

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "WATER" and "WIND" are visible.]*

023256 NOV-78

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28165

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FANIA GOLENDER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 30, 1986</b>                                  |  | 2b. HOUR<br><b>9:30 P.M.</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 2, 1896</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3405 POWHATAN AVE. 21216</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3405 POWHATAN AVE. 21216</b>                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVID KRITMAN</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CLARA PERLMUTTER</b>                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-46-5533</b>  |   | 17. INFORMANT<br><b>CLARITA GOLENDER</b><br><b>3405 POWHATAN AVE. BALTO., MD 21216</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac arrest</b>  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs</b><br><b>10 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 19 80</b> to <b>Oct 30 86</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>Oct 30 19 86</b> , and that in (my <del>own</del> ) opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>did</del> (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Andrew P. Wein</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>10/31/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Andrew P. Wein</b>  |  | 22e. ADDRESS<br><b>222 W. Gullspingway, Bal, Md 21216</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>11/1/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CREM</b>                          |  |
| 23d. LOCATION<br><b>BALTIMORE</b>   |  | COUNTY <b>MARYLAND</b>  |   |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC. 21215</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND</b>  |  |   |   |  |  |
| 25. DATE REC'D. BY REGISTRAR <b>NOV 5 1986</b>  |  |   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Dendron-Randall</b>  |  |   |   |  |  |

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20122 28

05931 28

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

00221982

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28166  
REG. NO.

|   |  |  |   |   |                            |   |  |
|---|--|--|---|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Lucille Goodwin</i> |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10 19 86</i> |   | 2b. HOUR<br><i>8:17A</i> M |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>4 14 16</i>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><i>70</i>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>South Carolina</i>              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Liberty Medical Center</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF MORNING LIFE)<br><i>RETIRED</i>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS ZIP CODE<br><i>911 Leander Hall Ct, 21230</i> |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY                                    |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Mackie Miller</i>                             |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Rose Brunson</i>                            |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>          |  | 16b. SOCIAL SECURITY NO.<br><i>216-36-3786</i> |  | 17. INFORMANT ADDRESS<br><i>Cynthia Mellerson 614 Woodbourne Ave</i>                         |  |   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Renal Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <i>8/22</i> , 19 <i>86</i> , to <i>10/19</i> , 19 <i>86</i> , that (we) lost saw the deceased alive on <i>10/19</i> , 19 <i>86</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>R. Haberman</i>  |  |   |  | DEGREE   |  | 22c. DATE SIGNED<br><i>10/19/86</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Ronald Haberman, M.D.</i>   |  |   |  | 22e. ADDRESS<br><i>6403A Apollo Dr, Baltimore, MD 21209</i>                    |  |   |  |

|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><i>BURIAL</i>                                  |  | 23b. DATE<br><i>10-25-86</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>CEDAR HILL</i>                        |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>ANNE ARUNDEL MD</i> |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>MARCH FUNERAL HOMES 1101 E. NORTH AVE</i> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>OCT 24 1986</i> |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-51885

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28167

REG. NO.

|   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
|---|--|--|--|---|--|--|--|--|--|---|--|---|--|--|--|--------------------|--|--------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH   |  | DAY   |  | YEAR   |  | 2b. HOUR           |  |                          |  |  |  |
| ALVIN   |  |  |  |   |  | GORDON   |  | 10/7/86  |  |   |  |   |  |  |  | 2:26am             |  |                          |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |   |  | 7. IF UNDER 1 YEAR  |  |  |  | 8. IF UNDER 24 HRS |  |                          |  |  |  |
| M   |  | W  |  | MONTH DAY YEAR<br>7 22 32   |  |  |  | 54 YRS   |  |   |  | MONTHS DAYS HOURS MIN.  |  |  |  |                    |  |                          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |   |  |  |  |                    |  |                          |  |  |  |
| MARYLAND  |  | USA  |  |   |  |  |  |  |  | BALTIMORE CITY MD.  |  |   |  |  |  |                    |  |                          |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                    |  |                          |  |  |  |
| BALTIMORE   |  | FRANCIS SCOTT KEY MEDICAL  |  |   |  |  |  |  |  | Businessman   |  |   |  | Food   |  |                    |  |                          |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE                                |  |   |  |  |  |                    |  |                          |  |  |  |
| MARYLAND  |  |  |  |   |  | BALTIMORE  |  |  |  | 4800 Yellowwood RD 21215                                      |  |   |  |  |  |                    |  |                          |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| FIRST MIDDLE LAST<br>DAVID GORDON   |  |  |  | FIRST MIDDLE LAST<br>Cecelia ESACOV                                 |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| YES KOREAN  |  |  |  | 215-32-882  |  |  |  | Stanley Gordon 3832 Janbrook Rd 21133  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                    |  |                          |  |  |  |
| IMMEDIATE CAUSE (a) CARDIAC ARREST  |  |  |  |   |  |  |  |  |  |   |  |   |  | 20 MINS.   |  |                    |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) HYPOTENSION  |  |  |  |   |  |  |  |  |  |   |  |   |  | 7 HRS  |  |                    |  |                          |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| DIABETES MELLITUS   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                    |  |                          |  |  |  |
|   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)               |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
|   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
|   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/6/86 to 10/7/86, that (I) (we) lost saw the deceased alive on 10/7/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 22b. SIGNATURE Scott Carnivale MD   |  |  |  |   |  |  |  |  |  |   |  |   |  | DEGREE   |  |                    |  | 22c. DATE SIGNED 10/7/86 |  |  |  |
|   |  |  |  |   |  |  |  |  |  |   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                    |  |                          |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCOTT CARNIVALE   |  |  |  |   |  |  |  | 22e. ADDRESS FRANCIS SCOTT KEY MEDICAL CENTER  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  |  | 23b. DATE 10-8-86   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY BETH JACOB  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE FINKSAURG CARROLL MD  |  |  |  |                    |  |                          |  |  |  |
|   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS 21208 HEBREW MEMORIAL FUNERAL HOME 1100 REISTERSTOWN RD   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 09 1986 Jane Davidson-Henderson  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |                    |  |                          |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed within 72 hours after death with the coroner's or medical examiner's office for retention or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or if a traumatic event, the medical examiner must be notified at once.

BP.

88-58107

107-100-1000

107-100-1000



00-20982

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28168  
REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>PENNY CATHERINE GORDON                                     |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/13/86<br>2b. HOUR<br>6:20 AM  |  |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 11 46 |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.                   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GEN. |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Factory<br>12b. KIND OF BUSINESS OR INDUSTRY<br>Same |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Balto. Highlands  | 13d. INSIDE CITY LIMITS?<br>NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Smith  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Baum   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>214-44-9875       |   | 17. INFORMANT<br>ADDRESS<br>Sharon Thompson 1802 Spence St. 21230  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Breast Ca.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (If this hospital) attended the deceased from <u>10/12</u> 19 <u>86</u> , to <u>10/13</u> 19 <u>86</u> , that (I) <u>(we)</u> last<br>saw the deceased alive on <u>10/13</u> 19 <u>86</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>(we)</u> (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><u>W. Rahmija</u>   |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>10/13/86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RATHMING   |  | 22e. ADDRESS<br>3001 S. HANOVER ST. 21230                              |  |  |   |

|  |                       |   |   |
|--|-----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                       | 23b. DATE<br>10/16/86 | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Pk. A.A. Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. |                       | 25a. DATE RECEIVED BY REGISTRAR<br>10/15/1986             | 25b. REGISTRAR'S SIGNATURE  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP \_\_\_\_\_

88 38188

88005-00

*[Faint, illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

00-21047

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28169

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SOPHIE R. GOSZKA</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 9, 1986</b>                       |  | 2b. HOUR<br>M<br><b>M</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 25, 1908</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                         |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1340 Crofton Road</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Telephone Operator - C. &amp; P.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13. STREET ADDRESS / ZIP CODE<br><b>1340 Crofton Rd. 21239</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lawrence Wzierzowski</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosalie Unknown</b>             |  | 16. SOCIAL SECURITY NO.<br><b>217-07-0468</b>   |  |
| 17. INFORMANT<br><b>Jean G. Kneavel</b>   |  | 18. ADDRESS<br><b>-1010 Green Acree Rd. 21204</b>                                   |  | 19. DATE OF OPERATION<br><b>11-21-19 68</b>   |  |
| 20. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 24. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                    |  | 25. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 26. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 27. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |  | 28. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 29. I certify that (I) (this hospital) attended the deceased from <b>9-19-86</b> to <b>10-9-1986</b> , that (I) (we) last saw the deceased alive on <b>9-19-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 30. SIGNATURE<br><b>K. A. Peter VanBerkum, M.D.</b>                                 |  | 31. DATE SIGNED<br><b>10/9/86</b>   |  |
| 32. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. A. Peter VanBerkum, M.D.</b>  |  | 33. ADDRESS<br><b>3925 Beech Avenue</b>   |  | 34. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>  |  |
| 35. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 36. DATE<br><b>10-11-86</b>   |  | 37. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b>  |  |
| 38. FUNERAL DIRECTOR<br><b>Ruck Towson Funeral Home, Inc.</b>   |  | 39. ADDRESS<br><b>1050 York Road Towson, Md. 21204</b>                              |  | 40. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

88163

00-2104

Close 2, 1

RECEIVED OCT 10 1952



x



x

3-21-52

THE CHIEF, ...

1-1-52

NO. 100-2104

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover pages 1 and 2 and completely fill in page 1. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

DHMH . 16 60M 7/B4  
(VRA 15. 4)

00-22313

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic experience, it should be notified at once.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8628170  
REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VERONICA Munson GOTTA</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>21</b> YEAR <b>86</b>  |  | 2b. HOUR<br><b>955 P M</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>09</b> DAY <b>02</b> YEAR <b>17</b>                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                              |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Carroll</b>  |  | 13c. CITY OR TOWN<br><b>Westminster</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE LAST <b>Munson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rose</b> MIDDLE LAST <b>Flynn</b>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>30 Louist St 21157</b>                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NOT APPLICABLE</b>   |  | 17. INFORMANT<br><b>Judith V Raffel</b> ADDRESS<br><b>433 Lemon Rd 2115</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.               |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-21</b> , 19 <b>86</b> , to <b>10-21</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 27b. SIGNATURE<br><b>Camille M. Henry MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |  | 27c. DATE SIGNED<br><b>10-21-86</b>   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Camille M. HENRY, M.D.</b>  |  |  |  | 27e. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |  |
| 28a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 28b. DATE<br><b>Oct. 24, 1986</b>  |  | 28c. NAME OF CEMETERY OR CREMATORY<br><b>St John's Church Cemetery Westminster Carroll MD</b> |  |
| 28d. FUNERAL DIRECTOR<br>NAME <b>Robert A. M...</b> ADDRESS <b>91 WILLIS ST WESTMINSTER, MD 21157</b>   |  | 28e. DATE OF BURIAL<br><b>OCT 27 1986</b>  |  | 28f. REGISTRAR'S SIGNATURE<br><b>Julia...</b>   |  |







BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to the burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8.6 28171  |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Brandon Eric Graham</b>   |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR<br><b>October 22, 1986</b>   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 22 86</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>1 17</b> |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |  |
| 13a STATE<br><b>MD</b>  |  |  |  | 13b. COUNTY<br><b>Balto.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Nathan Eric Graham</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rojeria Denise Robinson</b>                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>N/A</b>  |  | 16b SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Medical Records Dept<br/>827 Linden Ave. Balto., Md. 21201</b>                |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe Prematurity (22 weeks gestational age)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>October 22, 1986</b> to <b>October 22, 1986</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 22, 1986</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) <input checked="" type="checkbox"/> view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Mario R. Gonzales</b>  |  |  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mario Gonzales, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>10-30-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Anatomy Board</b>   |  | ADDRESS<br><b>Balto., Md.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 06 1986</b>  |  |
|   |  |  |  | 26. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Pendell</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked 0, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |   |  |                                    |  |
|---|--|--|--|--|--|---|--|--|--|---|--|------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>March</b> DAY <b>12</b> YEAR <b>1921</b>   |  | 2a. DATE OF DEATH MONTH <b>OCTOBER</b> DAY <b>27</b> YEAR <b>1986</b>                |  | 2b. HOUR<br><b>04:12a.m.</b>  |  |                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VIRGINIA S. GRAHAM</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                        |  | MD.   |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tool Co.</b>  |  |  |  |   |  |                                    |  |
| 13a. STATE<br><b>Penna.</b>   |  | 13b. COUNTY<br><b>Franklin</b>   |  | 13c. CITY OR TOWN<br><b>Waynesboro</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>515 Clayton Ave., 17268</b>                     |  | 97999   |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST <b>Howard</b> MIDDLE <b>L.</b> LAST <b>Steck</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Henrietta</b> MIDDLE <b>Elliott</b> LAST <b>Elliott</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>            |  | 16b. SOCIAL SECURITY NO.<br><b>177-16-0102</b>  |  | 17. INFORMANT<br><b>Donald A. Graham</b>   |  | ADDRESS<br><b>Waynesboro, Penna. 515 Clayton Ave. 17268</b>                   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>final diagnosis pending autopsy</b><br>(b) <b>hemorrhage into biliary system</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>liver failure &amp; ring catheter placed &gt; 3 days</b><br>(c) <b>probable percutaneous carcinoma</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10. |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b><br><b>72 hr</b> |  |                                    |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>none</b>  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  |  |  |   |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> OR EITHER, INJURY NEEDS EXAMINATION <input checked="" type="checkbox"/>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>N/A</b> <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b> |  | 21d. INJURY OCCURRED AT<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b> |  | 21f. LOCATION<br>(STREET) CITY OR TOWN COUNTY STATE<br><b>N/A</b>             |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/21</b> 19 <b>86</b> to <b>10/22</b> 19 <b>86</b> , that (I, we) last saw the deceased alive on <b>10/21</b> 19 <b>86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.   |  |  |  |  |  |   |  |  |  | 22b. SIGNATURE<br><b>[Signature]</b> DEGREE                                   |  | 22c. DATE SIGNED<br><b>9/22/86</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Augusto BASTIDAS</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital Dept of Phy</b>  |  |  |  |   |  |  |  |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>10/23/1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg Crematorium</b>                          |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Smithsburg Washington Md.</b>  |  |  |  |   |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>[Signature]</b> ADDRESS <b>50 S. Broad St. Waynesboro, PA</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |  |  |   |  |                                    |  |

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*Journal of Management Education*

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 8 1 7 3  
REG. NO.

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANKLIN M. GRAMMER</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 26 86</b>          |  | 2b HOUR<br>MIN.<br><b>5<sup>10</sup> P</b> |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 14 13</b>  |  |  |
| 6a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |  |  | 10b BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5706 The Alameda Apt.A 21239</b>     |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.Truck Driver</b>   |  |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>Blomeier Oil</b>  |  | 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>                          |  | 13b COUNTY<br><b>Baltimore</b>   |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Franklin Harrison Grammer</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Violet Annie Tagg</b>   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  |
| 16b SOCIAL SECURITY NO.<br><b>220-07-9654</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Melva M. Grammer 5706 Alameda Apt.A 21239</b>  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>MALIGNANT MELANOMA E METS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10</b><br><b>5 yes.</b> |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3 Sept 19 86</b> to <b>10/26 19 86</b> , that (I) (we) lost saw the deceased alive on <b>10/26 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dorothy Snow</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/27/86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DOROTHY SNOW</b>   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD BALT 21218</b>   |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10-29-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Pk.</b>   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  | 24 FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>   |  | 25a DATE REC'D BY REGISTRAR<br><b>OCT 29 1986</b>  |  |  |
| 25b REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Handwritten notes and scribbles in the upper right quadrant.

Handwritten initials or a small signature.

Handwritten notes and scribbles in the lower right quadrant.

00-21764

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23174

|   |  |                                     |  |  |  |   |  |   |  |   |  |   |  |
|---|--|-------------------------------------|--|--|--|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>MINERVA   |  | MIDDLE<br>GRANT                               |  | LAST<br>GRANT   |  | 20. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH<br>DAY<br>YEAR<br>10 19 86 |  | 26. HOUR<br>M<br>1:32<br>P.M.   |  |
| 3. SEX<br>F   |  | 4. RACE<br>B                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 18 1919  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>67 YRS. |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  | 21. DATE<br>PRONOUNCED<br>DEAD<br>MONTH DAY YEAR<br>10 19 86  |  | 27. HOUR<br>M<br>1:32<br>P.M.   |  |
| 8. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>N.C.   |  |                                     |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  |   |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                         |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore  |  |                                     |  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Key Medical Center   |  |   |  | 14. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Garment Worker   |  |   |  | 15. KIND OF BUSINESS<br>OR INDUSTRY<br>Clothing                                     |  |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |                                     |  | 13b. CITY OR TOWN<br>Balto   |  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  | 13d. STREET ADDRESS<br>210 Center St. 21222   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James S. Hockaday   |  |                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minerva Faulcon   |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>(IF YES, GIVE WAR OR DATES)   |  |   |  | 17. SOCIAL SECURITY NO.<br>098-20-7733  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                     |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |   |  | 19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Diabetes mellitus</u> |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 19a. DATE OF OPERATION  |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                                     |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |  | DATE SIGNED 10-20-86  |  |
| ACTUAL SIGNATURE<br><u>Charles P. Kokes</u>   |  |                                     |  | EXAMINER'S NAME<br>(TYPE OR PRINT) Charles P. Kokes, M.D.  |  |   |  | ADDRESS<br>111 Penn St., Balto., MD 21201   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                                     |  | 23b. DATE<br>10-23-86  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pine Lawn   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Nassau Co. N.Y.                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James A. Marton + Sons  |  |                                     |  | ADDRESS<br>1701 Laurens  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1986  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                    |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 4888-175

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | THOMAS D. GRANT   |  | 10 7 86 2400 M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| 35 MALE   |  | BLACK  |  | MONTH DAY YEAR<br>1 10 53   |  | 33 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| 3 MARYLAND  |  | U.S.A.   |  |   |  | BALTIMORE MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE   |  | UNIV. OF MD. CANCER CENTER   |  | UNEMPLOYED  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                       |  |
| md.   |  |  |  | Baltimore   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS / ZIP CODE  |  |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | 218 Chase St 21202  |  |  |  |
| WILLIAM GRANT   |  | EVA CALDWELL   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |
| NO  |  | 217565991  |  | EVA BOYKIN  |  | 1314 Caroline St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEAD AND NECK CANCER - METASTATIC</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 MONTHS.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 7, 1986</u> to <u>OCTOBER 8, 1986</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 8, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>WILLIAM H. WEISS, MD.</u>  |  |  |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>10-18-86</u>                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>WILLIAM H. WEISS, MD.</u>   |  |  |  | 22e. ADDRESS<br><u>UNIV OF MD HOSPITAL PAVILION</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |
| <u>Burial</u>   |  | <u>10-13-86</u>  |  | <u>Mt. Calvary Cem.</u>   |  | <u>Anne Arundel County, MD</u>                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| <u>CALVIN B. SCRUGGS</u><br><u>1412 E. Preston St</u>   |  |  |  | <u>OCT 09 1986</u><br><u>[Signature]</u>  |  |  |  |

BP \_\_\_\_\_





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Items 13a.-13c.  
 1- STATE REGISTRAR *Perphone 10-17-86*  
 R.L.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 6 2 8 1 7 1  
 REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>BABY GIRL GRAY  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 - 4 - 86 |  |  | 2b. HOUR<br>10 14 AM  |  |
| 3 SEX<br>Female                                       |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 3 86  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br>0                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.               |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV MD Hosp |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                     |  | 13a. CITY OR TOWN<br>Balto  |  | 13b. STREET ADDRESS / ZIP CODE<br>4400 Palmer Ave. 21215   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST                 |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Delores Gray  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT   |  | ADDRESS   |  |  |  |   |  |

|  |  |  |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF,<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Prevalability</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

|  |  |  |  |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>10-3</u> , 19 <u>86</u> , to <u>10-4</u> , 19 <u>86</u> , that (I) <u>we</u> saw the deceased alive on <u>10-4</u> , 19 <u>86</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I <u>we</u> ) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>George R Kim</u> MD<br>DEGREE   |  | 22c. DATE SIGNED<br>10-4-86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE R. Kim   |  | 22e. ADDRESS<br>UNIV MD Hosp.  |  |

|   |  |                      |  |  |  |  |  |
|---|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal |  | 23b. DATE<br>10-9-86 |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Anatomy Board            |  |                      |  | ADDRESS<br>Balto., Md.                                   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986 |  |
|   |  |                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Seaton-Rudner</u> |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 72 hours after death. Page 1 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and taken to the funeral home, it is to be returned to the funeral director. In by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove containing page. Page 3 should be returned to the funeral director. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, checked on, explain that be noted on page 3.

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1940-1941

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|--|--|---|---|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CARRIE M. GRAY       |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-22-86 |  | 2b. HOUR<br>M |  |
| 3. SEX<br>F  |  | 4. RACE<br>B  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 1 34   |               |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.                                       |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA    |   | 8. CITIZEN OF WHAT COUNTRY?<br>USA   |               |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                            |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE                        |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS |               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Postal Clerk |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Post Office              |   | 13a. STREET ADDRESS / ZIP CODE<br>2515 Oswego Ave  |               |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore   |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LINDSEY G. BYRD                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JULIA BARLEY |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |               |  |
| 16b. SOCIAL SECURITY NO.<br>239-467171   |  | 17. INFORMANT<br>Carl V. Gray                                 |   | ADDRESS<br>2515 Oswego Ave   |               |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PANCREATIC MASS<br>DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC INSUFFICIENCY<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 10-8, 1986, to 10-22, 1986, that (I) (we) last saw the deceased alive on 10-22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>J. Parker  |  | DEGREE<br>MD   |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |  | 22c. DATE SIGNED<br>10-22-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JEFF PARKER MD  |  | 22e. ADDRESS<br>2300 GARRISON BLVD                                     |  |   |  |  |  |

|  |  |                       |  |   |  |   |  |
|--|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                        |  | 23b. DATE<br>10/28/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co Md |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue |  |                       |  | 25a. DATE REC'D BY REGISTRAR<br>OCT 28 1986             |  | 25b. REGISTRAR'S SIGNATURE                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial or funeral. Then please submit this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 1 7 9  
REG. NO.

|   |  |   |        |   |                          |  |                                |   |      |  |   |
|---|--|---|--------|---|--------------------------|--|--------------------------------|---|------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE | LAST  | 2a. DATE OF DEATH        |  | MONTH                          | DAY   | YEAR | 2b. HOUR   |   |
| Meigs   |  |   |        | Greathouse, Sr.   | 10/27/86                 |  |                                |   |      | 2202 M   |   |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS  |   |
| Male  |  | White   |        | MONTH DAY YEAR<br>6 8 19  |                          | 67 YRS   |                                | MONTHS DAYS   |      | HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                |   |      |  |   |
| W. Virginia   |  | U.S.A.  |        |   |                          | Baltimore City MD.   |                                |   |      |  |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                | 12b. KIND OF BUSINESS OR INDUSTRY                                   |      |  |   |
| Baltimore   |  | Saint Agnes Hospital  |        |   |                          | Machinist  |                                | Steel co.   |      |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |        |   | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS / ZIP CODE |   |      |  |   |
| 13a. STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                | 2628 Lehman Street 21223  |      |  |   |
| Maryland  |  |   |        | Baltimore   |                          |  |                                |   |      |  |   |
| 14. FATHER'S NAME   |  |   |        | 15. MOTHER'S MAIDEN NAME  |                          |  |                                |   |      |  |   |
| FIRST   |  | MIDDLE  |        | LAST  |                          | FIRST  |                                | MIDDLE  |      | LAST   |   |
| Rubin   |  |   |        | Greathouse  |                          | Dessie   |                                |   |      | Lipscomb   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |        | 16b. SOCIAL SECURITY NO.  |                          | 17. INFORMANT ADDRESS  |                                |   |      |  |   |
| YES   |  |   |        | WW II   |                          | R. Sharon Cole 3750 Squirewood Dr. 27012                                       |                                |   |      |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>hepatic encephalopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hepatic alcohol cirrhosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>portal hypertension</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. |  |   |        |   |                          |  |                                |   |      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|   |  |   |        |   |                          |  |                                |   |      |  |   |
| 19a. DATE OF OPERATION  |  |   |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |  |                                | 20a. AUTOPSY?   |      | 20b. IF YES, WERE FINDINGS USED<br>IN IDENTIFYING CAUSES OF DEATH? |   |
|   |  |   |        |   |                          |  |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      | YES <input type="checkbox"/> NO <input type="checkbox"/>           |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |                                |   |      |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                |   |      |  |   |
|   |  |   |        |   |                          |  |                                |   |      |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/16</u> , 19 <u>86</u> , to <u>10/28</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |        |   |                          |  |                                |   |      |  |   |
| 22b. SIGNATURE  |  |   |        | DEGREE  |                          |  |                                | 22c. DATE SIGNED  |      |  |   |
| <u>Alvin Madarang</u>   |  |   |        | M.D.  |                          |  |                                | 10-28-86  |      |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |        | 22e. ADDRESS  |                          |  |                                |   |      |  |   |
| Dr. Madarang  |  |   |        | 900 S. Caton Ave. Balto. MD 21229   |                          |  |                                |   |      |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |                          | 23d. LOCATION  |                                | COUNTY  |      | STATE  |   |
| Burial  |  | 10/30/86  |        | Loudon Park Cemetery  |                          | Baltimore  |                                | Maryland  |      |  |   |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |        | 25a. DATE REC'D. BY REGISTRAR   |                          | 25b. REGISTRAR'S SIGNATURE   |                                |   |      |  |   |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229  |  |   |        | OCT 29 1986   |                          |  |                                |   |      |  |   |

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XXXXXX

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0-20196

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 1 8 0  
REG. NO.FOR  
STATE  
REGISTRAR

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edith C. Gregory  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 4 86                                |   | 2b. HOUR<br>9:15   |
| 3. SEX<br>F  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 5 07   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Baltimore   | 7b. CITIZEN OF WHAT COUNTRY?<br>- U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balti. Md. MD.                        |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John N. L. Deaton Medical Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1343 Andrie St. 21230  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gilbert Zeller   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna -   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  | 17. INFORMANT<br>ADDRESS<br>818-03-3181 Betty Lawa 1343 Andrie St. 21230      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute Bilateral Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cerebral Vascular Accident                       |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1913, 19 13, to Oct 19 86, that (I) (we) last saw the deceased alive on Oct 3 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br>Sandra L. Howard   |   | DEGREE<br>MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |   | 22c. DATE SIGNED<br>10-4-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sandra L. Howard MD.  |   | 22e. ADDRESS<br>1600 S. Charles St. 21230   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)  | 23b. DATE<br>10/7/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md.                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Charles S. Stevens 1501 E. Pratt St.   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 07 1986  |   |   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br>John L. ...   |   |   |  |

0-50180

70

100

00-2229

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

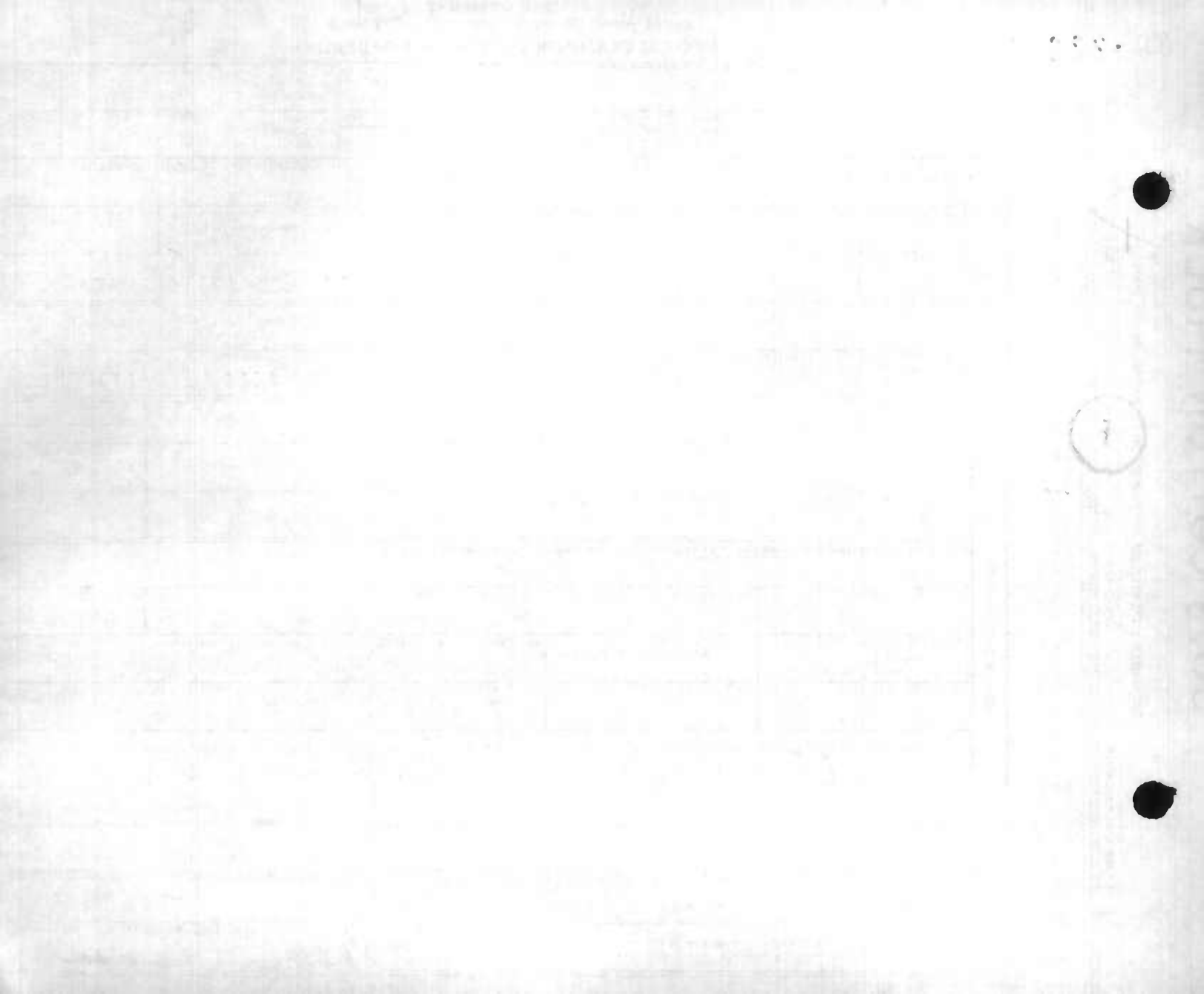
REG. NO.

|   |  |                  |  |   |  |   |  |   |  |                                |  |   |  |  |  |           |  |  |  |
|---|--|------------------|--|---|--|---|--|---|--|--------------------------------|--|---|--|--|--|-----------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  |  | 2a. DATE KNOWN OF DEATH   |  |   |  | 2b. DATE OF DEATH   |  |                                |  | 2c. DATE PRONOUNCED DEAD  |  |  |  | 2d. HOUR  |  |  |  |
| FIRST<br>Gregory  |  |                  |  | MIDDLE<br>Green   |  |   |  | LAST<br>Green   |  |                                |  | MONTH<br>10/22/19   |  |  |  | DAY<br>86 |  |  |  |
| 3. SEX<br>M   |  | 4. RACE<br>BLACK |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 29 65   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>21 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2e. HOUR<br>2:15 P M  |  |  |  |           |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>FLORIDA  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |  |           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4700 Blk. Franklinton Rd. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AUTO MECHANIC  |  |                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>--   |  |  |  |           |  |  |  |
| 13a. STATE<br>MD  |  |                  |  | 13b. COUNTY<br>BALTO.   |  |   |  | 13c. CITY OR TOWN<br>BALTO.   |  |                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |           |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAM ANDREW  |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>REBECCA GREEN  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |                                |  | 16b. SOCIAL SECURITY NO.<br>215804283   |  |  |  |           |  |  |  |
| 17. INFORMANT<br>REBECCA GREEN  |  |                  |  | 17. ADDRESS<br>2416 W. BALTIMORE ST.  |  |   |  | 17. ADDRESS<br>2416 W. BALTIMORE  |  |                                |  | 17. ADDRESS<br>2416 W. BALTIMORE  |  |  |  |           |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Gunshot Wounds<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |   |  |   |  |   |  |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |           |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.   |  |                  |  |   |  |   |  |   |  |                                |  |   |  |  |  |           |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                |  |   |  |  |  |           |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 10/ /1986   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject found shot   |  |                                |  |   |  |  |  |           |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>park   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>4700 Blk. Franklinton Rd., Balto. City, Md.  |  |                                |  |   |  |  |  |           |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |                                |  |   |  |  |  |           |  |  |  |
| ACTUAL SIGNATURE<br>[Signature]   |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER  |  |                                |  | DATE SIGNED<br>10/23/86   |  |  |  |           |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.   |  |                  |  | ADDRESS<br>111 Penn St.   |  |   |  |   |  |                                |  |   |  |  |  |           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |                  |  | 23b. DATE<br>10-27-86   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. AUBURN CEMETERY   |  |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD   |  |  |  |           |  |  |  |
| 24. FUNERAL DIRECTOR<br>MARCH FUNERAL HOMES   |  |                  |  | ADDRESS<br>1101 E. NORTH AVE.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1986  |  |                                |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |           |  |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT FILE. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))



00-21439

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/B3  
(VRA 15, 4)

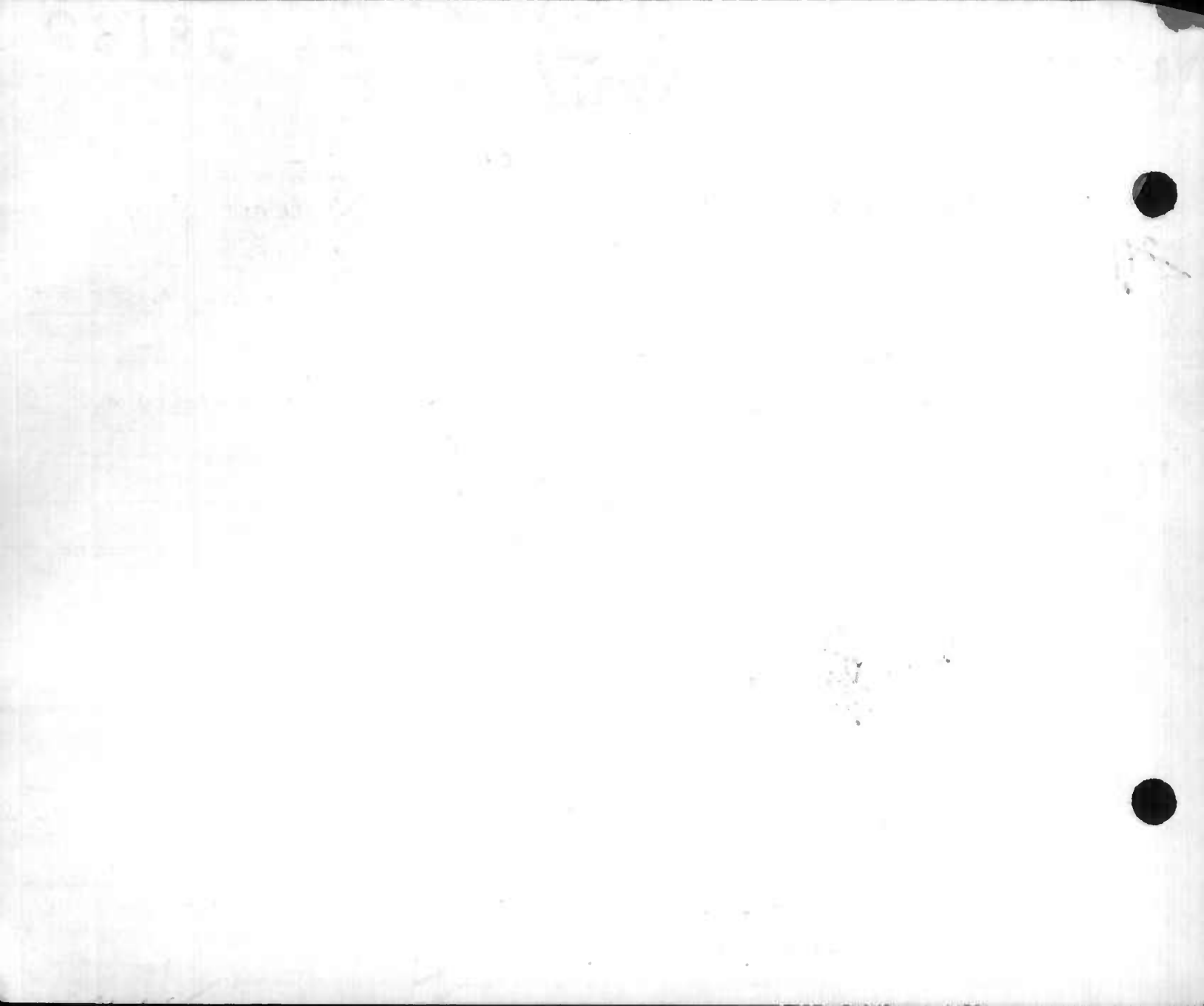
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28182

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                         |  |  |  |   |  |   |  |   |  |
|---|--|-------------------------|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frederick Green</b>  |  |                         | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>13</b> YEAR <b>86</b>  |  |  | 2b. HOUR<br><b>8:15 PM</b>  |  |   |  |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>26</b> YEAR <b>94</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | 8. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sis. Hospital of Baltimore</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |  |  |  | 13a. STATE<br><b>MD</b>   |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>  |   |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                         |  |  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>3811 HAYWOOD Ave 21215</b>   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>EDWARD</b> MIDDLE <b>-</b> LAST <b>GREEN</b>  |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNA</b> MIDDLE <b>-</b> LAST <b>-</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>   |  |                         |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>185-10-0929</b>  |  |   |  |   |  |
| 17. INFORMANT<br><b>FREDERICK C. Green JR.</b>  |  |                         |  |  |  | ADDRESS<br><b>716 N Charles 21201</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>sepsis</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF <b>brain damage</b><br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                         |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:  |  |                         |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                         | 21b. TIME OF INJURY<br>HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b> YEAR <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased _____ on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                         |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>J. Chaloupka</b>   |  |                         |  |  |  | DEGREE<br><b>M.D.</b>   |  |   | 22c. DATE SIGNED<br><b>10/13/86</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sols C. CHALOUKKA</b>   |  |                         |  |  |  | 22e. ADDRESS<br><b>Sis. Hospital of Baltimore</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(b) <b>BURIAL</b>  |  |                         | 23b. DATE<br><b>10-18-86</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Anne Arundel</b> COUNTY <b>MD</b> STATE   |   |  |
| 24. FUNERAL DIRECTOR<br><b>MARCH F/H 1101 E. NORTH Ave.</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1986</b>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |





0-22999

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28183

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |                  |  |  |   |   |
|---|------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Morris T. Greene  |                  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 29 1986                            |   | 2b. HOUR<br>M   |
| 3. SEX<br>male  | 4. RACE<br>black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 8 27                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59<br>YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city  |                  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                       |   |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1928 N. Fulton Avenue  |                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Disabled |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Md  |                  |  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard T. Greene   |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucy Alexander              |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>226-20-4519                                |  | 17. INFORMANT ADDRESS<br>Raymond Greene 34 S. Morley Street   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CA Esophagus rupt 1/3</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>stage IV</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>stage IV</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>N/A</u> |                  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 mos.</u>   |
| 19a. DATE OF OPERATION<br><u>N/A</u>  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 8, 1986</u> to <u>Aug 8, 1986</u> that (I) (we) lost<br>saw the deceased alive on <u>Aug 8, 1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |                  |  |  |   |   |
| 22b. SIGNATURE<br><u>Simon Weiner</u>   |                  | DEGREE   |  | 22c. DATE SIGNED<br><u>10/30/86</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>S. WEINER M.D.</u>  |                  | 22e. ADDRESS<br><u>1900 Northern Hwy</u>                               |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                  | 23b. DATE<br>11/4/86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Cemetery                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>11-7-1986</u>                            |   | 25b. REGISTRAR'S SIGNATURE<br><u>John T. Rudek</u>  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

38255-0



00-21589

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28184  
2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR ☐ HOUR  
10-16-86  
2b. DATE PRONOUNCED DEAD 10-16-86  
6:45P

1- FOR STATE REGISTRAR

|  |         |   |  |  |  |                                      |  |                                    |  |                                   |  |
|--|---------|---|--|--|--|--------------------------------------|--|------------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |         | FIRST   |  | MIDDLE   |  | LAST                                 |  | 2a. DATE KNOWN OF DEATH            |  | 2b. DATE PRONOUNCED DEAD          |  |
| MARIE H. GREESON   |         |   |  |  |  |                                      |  | 10-16-86                           |  | 6:45P                             |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.                       |  | IF UNDER 24 HRS.                   |  | 7c. DATE PRONOUNCED DEAD          |  |
| FEMALE   | CAUCAS. | 09 23 15  |  | 71 YRS.  |  |                                      |  |                                    |  | 10-16-86                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                    |  |                                   |  |
| MARYLAND   |         | USA   |  |  |  | Baltimore City MD                    |  |                                    |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  | 12a. USUAL OCCUPATION                |  | 12b. TYPE OF WORK                  |  | 12c. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore  |         | 904 N. Chester Street   |  |  |  | HOUSEWIFE                            |  |                                    |  | ----                              |  |
| 13a. STATE   |         |   |  |  |  |                                      |  |                                    |  |                                   |  |
| MARYLAND   |         |   |  |  |  |                                      |  |                                    |  |                                   |  |
| 13b. COUNTY  |         |   |  |  |  |                                      |  |                                    |  |                                   |  |
| BALTIMORE  |         |   |  |  |  |                                      |  |                                    |  |                                   |  |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |         |   |  |  |  |                                      |  |                                    |  |                                   |  |
| 13d. STREET ADDRESS  |         |   |  |  |  |                                      |  |                                    |  |                                   |  |
| 904 N. Chester St. 21205   |         |   |  |  |  |                                      |  |                                    |  |                                   |  |
| 14. FATHER'S NAME  |         |   |  | 15. MOTHER'S MAIDEN NAME   |  |                                      |  | 16. SOCIAL SECURITY NO.            |  |                                   |  |
| JAMES HORAN  |         |   |  | MARGARET (REINIG) FREITAG  |  |                                      |  | 215-12-7180                        |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                           |         |   |  | 16b. SOCIAL SECURITY NO.   |  |                                      |  | 17. INFORMANT ADDRESS              |  |                                   |  |
| NO   |         |   |  | 215-12-7180  |  |                                      |  | DOLORES K. SHAMER 3210 MT. ZION RD |  |                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

cachexia

19a. DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  
20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 10-17-86

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

|                                 |           |                                    |                            |                            |       |
|---------------------------------|-----------|------------------------------------|----------------------------|----------------------------|-------|
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY                     | STATE |
| BURIAL                          | 10/20/86  | MORELAND MEMORIAL                  | BAITO.                     | BAITO.                     | MD.   |
| 24. FUNERAL DIRECTOR NAME       |           | 25a. DATE REC'D. BY REGISTRAR      |                            | 25b. REGISTRAR'S SIGNATURE |       |
| <u>[Signature]</u>              |           | OCT 20 1986                        |                            | <u>[Signature]</u>         |       |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN THE SPACE PROVIDED. IN THE CASE OF A MEDICAL EXAMINER, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, REMOVAL.

ASICS 25

00-51010

1

0-21537

86 28185

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR

|   |  |                  |                 |   |  |              |   |   |   |   |  |   |  |                                   |   |   |  |                      |  |  |
|---|--|------------------|-----------------|---|--|--------------|---|---|---|---|--|---|--|-----------------------------------|---|---|--|----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  | FIRST<br>Bessie |   |  | MIDDLE<br>P. |   |   | LAST<br>Griffin                               |   |  | 2a. DATE OF DEATH<br>ESTIMATED  |  |                                   | <input checked="" type="checkbox"/> MONTH<br>10/ 17/19 86 |   |  | 2b. HOUR<br>6:56 P M |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>black |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 6 1924   |  |              | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>62 YRS. |   | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |   | 2c. DATE PRONOUNCED DEAD<br>10/ 17/19 86 |   |  | 2d. HOUR<br>P M                   |   |   |  |                      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md                             |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |              |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |                                   |   |   |  |                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                      |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3707 Nortonia Rd. |  |              |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Housewife |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |   |  |                      |  |  |
| 13a. STATE<br>Md  |  |                  |                 | 13b. COUNTY   |  |              |   | 13c. CITY OR TOWN<br>Baltimore  |   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |   | 13e. STREET ADDRESS<br>3707 Nortonia Road 21216 |  |                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George T. Pumphrey                |  |                  |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Scott  |  |              |   |   |   |   |  |   |  |                                   |   |   |  |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No |  |                  |                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  |              |   | 17. INFORMANT ADDRESS<br>Anthony Griffin 4701 Belwood Green Avenue 2nd Floor  |   |   |  |   |  |                                   |   |   |  |                      |  |  |

|   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cirrhosis &amp; Arteriosclerotic Hypertensive Cardiovascular</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Disease |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .                      |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>William M. Zane</u>   |  |  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER |  |   |  |  |  | DATE SIGNED 10/18/86  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>William M. Zane, M.D.  |  |  |  |   |  | ADDRESS<br>111 Penn St.                            |  |   |  |  |  |   |  |  |  |  |  |

|  |  |                       |  |   |  |  |  |
|--|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                |  | 23b. DATE<br>10/21/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Home West 4300 Wabash Avenue |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1986                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>William M. Zane</u>       |  |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M  
BP  
DHMH - 17  
(VR A15 ME (5))

30% COTTON FIBER

MADE IN AUSTRIA



5-1232



0-21477

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and consistently filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical investigation must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28186  
REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARVIN W. GROOMS JR</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>15</b> YEAR <b>86</b>  |  | 2b. HOUR <b>1030</b> AM <b>A</b>  |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>5</b> YEAR <b>30</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |   |  |
| 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH. BALT. GEN. HOSP</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Boiler Tech.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Mfg</b>  |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>A.A.</b>  |  | 13c. CITY OR TOWN <b>SEVERN</b>   |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE <b>21144</b><br><b>7966 Foster Avenue</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>MARVIN</b> MIDDLE <b></b> LAST <b>GROOMS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b></b> LAST <b>EDGAR</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>216-28-1848</b>  |  | 17. INFORMANT <b>Severn, Maryland 21144</b><br><b>Wendy A. Grooms 7966 Foster Avenue</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Uro sepsis, Right Lower lobe pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> 19 <b>86</b> , to <b>10/15</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/15</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>B. Pimentel</b>  |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. PIMENTEL</b>   |  | 22e. ADDRESS<br><b>South. Balt. Gen. Hosp. 3001 So. Hanover</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>10/16/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>  |  |
| 23d. LOCATION<br>(CITY OR TOWN) <b>Catonsville Balto</b>  |  | 23e. STATE <b>Md</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Raymond C. Fink</b> ADDRESS <b>Glen Burnie, Md. 21061</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>J. W. Anderson</b>  |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

28187

REG. NO.

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MATTIE</b>  |  | FIRST<br><b>GROSS</b>   |  | LAST   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/22/86</b>  |  | 2b. HOUR<br><b>6:15 P</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/16/24</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>62</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALTO</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4201 Liberty Hgts. 21201</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James P Barnes</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MATTIE ATKINSON</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>229-30-6493</b>  |  | 17. INFORMANT ADDRESS<br><b>Lawrence Gross 4201 Liberty Hgts</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pulmonary metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Breast Cancer</b> |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> , 19 <b>86</b> , to <b>10/22</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/22</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                            |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>HANADI SHANKHANI</b>   |  |   |  | DEGREE<br><b>MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>10/22/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HANADI SHANKHANI</b>  |  |   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTO</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10-28-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALvary Cem. BALTO.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. M.D.</b>                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Phillips Funeral Home</b>  |  |   |  | ADDRESS<br><b>P.A. 1721 N. Monroe St.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 30 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be autopsied within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

73-52-38

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1. The first part of the report is a summary of the work done during the past year. It includes a list of the projects which have been completed, and a brief description of the results obtained. The second part of the report is a detailed account of the work done on the project entitled "The effect of temperature on the rate of reaction between hydrogen peroxide and potassium iodide". This work was carried out by Mr. J. H. Smith, and the results are given in the table on page 10.

2. The third part of the report is a description of the work done on the project entitled "The effect of concentration on the rate of reaction between hydrogen peroxide and potassium iodide". This work was carried out by Mr. J. H. Smith, and the results are given in the table on page 15. The fourth part of the report is a description of the work done on the project entitled "The effect of pH on the rate of reaction between hydrogen peroxide and potassium iodide". This work was carried out by Mr. J. H. Smith, and the results are given in the table on page 20.

3. The fifth part of the report is a description of the work done on the project entitled "The effect of catalyst on the rate of reaction between hydrogen peroxide and potassium iodide". This work was carried out by Mr. J. H. Smith, and the results are given in the table on page 25. The sixth part of the report is a description of the work done on the project entitled "The effect of surface area on the rate of reaction between hydrogen peroxide and potassium iodide". This work was carried out by Mr. J. H. Smith, and the results are given in the table on page 30.

4. The seventh part of the report is a description of the work done on the project entitled "The effect of temperature on the rate of reaction between hydrogen peroxide and potassium iodide". This work was carried out by Mr. J. H. Smith, and the results are given in the table on page 35. The eighth part of the report is a description of the work done on the project entitled "The effect of concentration on the rate of reaction between hydrogen peroxide and potassium iodide". This work was carried out by Mr. J. H. Smith, and the results are given in the table on page 40.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 86 28188   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PHILIP E. GROSSFIELD</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 18, 1986</b>                       |   |  | 2b. HOUR<br><b>1:35 PM</b>                                       |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 20, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BOOK STORE</b>           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4510 BELVIEW AVE. 21215</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN GROSSFIELD</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE FRIEDMAN</b>              |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF NOT KNOWN, WRITE "UNKNOWN")<br><b>050-14-6669</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. RACHEL GROSSFIELD 4510 BELVIEW AVE. 21215</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>perforated colon</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min.</b><br><b>1 hr.</b><br><b>1 month</b> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>perforated colon</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>10/17</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>125 P.M. 10 18 1986</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> 19 <b>86</b> , to <b>10/18</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/18</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>L. Schulteis</b>   |  |  |  | DEGREE<br><b>MD; MD.</b>  |  |   |  | 22c. DATE SIGNED<br><b>10/18/86</b>                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. Schulteis</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10/20/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1986</b>                                  |   |  |  |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director for page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72-hour statement with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by mail.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |   |   |
|--|--|---|--|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ETHEL GROSSKOPF</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 11, 1986</b>                                  |  |  | 2b. HOUR<br><b>1:35p<sub>M</sub></b>  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 15 1919</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> / YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                    |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>2903 Jefferson St. 21205</b>     |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Dillman</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Dwyer</b>                              |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-9257</b>  |  | 17. INFORMANT ADDRESS<br><b>John Grosskopf 2903 Jefferson St.</b>   |   |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cerebrovascular Accident</b><br>(b) <b>Brain Stem</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |   |  |   |   |  |  |   |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9. 17</b> 19 <b>86</b> , to <b>10. 11</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10. 11. 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |   |   |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   |  |   | DEGREE  |  |  | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>I. A. Ferow</b>  |  |   |  |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORP.<br/>100 N. Broadway, Balto. Md. 21231</b>              |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>10/15/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>UCT 14 1986</b>                  |  |  |   |   |

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00-22253

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  |
|--|--|--|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 86 28190  |  |   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>WALTER FRANCIS GROW  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10/24/86                     |   |   | 2b. HOUR<br>1355 M   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 19, 1915   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                      |   | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 72 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Phila, Penn.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                      |   |  |  |
| 11. CITY OR TOWN OF DEATH<br>BALTIMORE CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL Balto. Md. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Balto.   |  |  |  |   | 13c. CITY OR TOWN<br>Baltimore                                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Frank ----- Grow  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna ----- Patrick |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes, W.W.2, Korean   |  | 16b. SOCIAL SECURITY NO.<br>186-10-0658  |  | 17. INFORMANT ADDRESS<br>Michael F. Grow, Same as above   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>S/P Cardiac arrest + v. fibrillation - 10.23.86</u>  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 25</u> , 19 <u>84</u> , to <u>10 24</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>10 24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  | DEGREE<br><u>M.D.</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |   | 22c. DATE SIGNED<br><u>10 24 86</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>GROWER</u>   |  |  |  | 22e. ADDRESS<br><u>ST Agnes Hosp Balto Md.</u>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/28/1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville, Cemt.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville, Md.                  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>McCully Funeral Home, Balto. Md. 21225  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                |   |  |  |

COTTON FIBRE



00-21972

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and place them in the appropriate boxes on page 4. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8628191

|  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2. DECEASED NAME (TYPE OR PRINT)                                    |  | 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7a. DATE OF DEATH  |  | 7b. HOUR  |  |
|  |  | DORA  |  | FEMALE   |  | CAUCASIAN  |  | MAY 14 1918                                      |  | 68 YRS.  |  | OCT. 17, 1986  |  | 4:18 A.M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. CITY OR TOWN OF DEATH                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| POLAND   |  | USA   |  |  |  | BALTIMORE CITY MD.   |  | BALTIMORE  |  | KEVINAVE HEBRON GERIATRIC CENTER + Hospital  |  | HOUSEWIFE  |  | AT HOME   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS / ZIP CODE                   |  | 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  |
| MARYLAND   |  |   |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 3626 GLEN GYLE AVE. 21215                        |  | UNKNOWN  |  | UNKNOWN  |  | NO  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 19c. AUTOPSY?  |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  | 20. SIGNATURE   |  |
| 215-60-6205  |  | MRS. RITA FRAIMAN 6809 FAIRLAWN AVE. 21215                          |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | ESTRELITA O. KU, M.D.   |  |
| 21. INJURY OCCURRED  |  | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  | 21d. LOCATION                                    |  | 21e. ADDRESS   |  | 21f. DATE SIGNED   |  | 21g. REGISTRAR'S SIGNATURE  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | STREET CITY OR TOWN COUNTY STATE                 |  | KEVINAVE HEBRON GERIATRIC CENTER + Hospital  |  | 10/17/86   |  | SOL LEVINSON & BROS., INC.  |  |
| 22a. I certify that (this hospital) attended the deceased from   |  | 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS                                     |  | 22f. DATE REC'D. BY REGISTRAR  |  | 22g. REGISTRAR'S SIGNATURE                                     |  | 22h. DATE REC'D. BY REGISTRAR                                     |  |
| saw the deceased alive on 10/17/86, and that (we) (our) opinion of death occurred on the date and hour and from the causes stated above. |  | ESTRELITA O. KU, M.D.   |  | 10/17/86   |  | KEVINAVE HEBRON GERIATRIC CENTER + Hospital                                    |  | 10/17/86   |  | OCT 23 1986  |  | SOL LEVINSON & BROS., INC.                                     |  | OCT 23 1986   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | 23e. FUNERAL DIRECTOR                            |  | 23f. DATE REC'D. BY REGISTRAR  |  | 23g. REGISTRAR'S SIGNATURE                                     |  | 23h. DATE REC'D. BY REGISTRAR                                     |  |
| BURIAL   |  | 10/17/86  |  | CHEVRA AHAVAS CHESD  |  | RANDALLSTOWN BALTO MD  |  | SOL LEVINSON & BROS., INC.                       |  | OCT 23 1986  |  | SOL LEVINSON & BROS., INC.                                     |  | OCT 23 1986   |  |
| 24. FUNERAL DIRECTOR   |  | 24a. NAME   |  | 24b. ADDRESS   |  | 24c. DATE REC'D. BY REGISTRAR  |  | 24d. REGISTRAR'S SIGNATURE                       |  | 24e. DATE REC'D. BY REGISTRAR  |  | 24f. REGISTRAR'S SIGNATURE                                     |  | 24g. DATE REC'D. BY REGISTRAR                                     |  |
| SOL LEVINSON & BROS., INC.   |  | 6010 REISTERSTOWN RD. BALTO, MD 21215                               |  |  |  | OCT 23 1986  |  | SOL LEVINSON & BROS., INC.                       |  | OCT 23 1986  |  | SOL LEVINSON & BROS., INC.                                     |  | OCT 23 1986   |  |

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UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF

1. The purpose of this report is to provide a summary of the results of the study conducted by the Research and Development Division, Office of the Chief of Staff, Department of the Army, during the period from 1 January 1960 to 31 December 1960.

2. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

3. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

4. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

5. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

6. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

7. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

8. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

9. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

10. The study was conducted in accordance with the instructions of the Chief of Staff, Department of the Army, dated 15 October 1959, and the instructions of the Research and Development Division, Office of the Chief of Staff, dated 10 November 1959.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 8 2 8 : 9 2  
REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b. HOUR<br>M  |  |
| JOHN   |  | GEORGE  |  | GUNKEL, JR.   |  | October 9, 1986  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 1, 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3622 Chesterfield Ave. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Oil Co.   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John George Gunkel   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Altvater  |  | 13e. STREET ADDRESS / ZIP CODE<br>3622 Chesterfield Avenue 21213  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-03-0208  |  | 17. INFORMANT<br>Carroll Gunkel, 10254 Arizona Cir.   |  | ADDRESS: Bethesda, Md. 20817   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Ischemic H. D. Decompensation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>2 months</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-1-86</u> to <u>10-1-86</u> , that I (we) (last saw the deceased alive on <u>10-1-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Dr. Harold H. Burns</u> M.D.  |  |   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>10-13-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold Burns, M.D.  |  |   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Oct. 13, 1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.  |  |   |  | ADDRESS<br>Baltimore, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse side, it should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8-6-NO. 28193  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Alston  |  | MIDDLE<br>H   |  | LAST<br>GUNTER  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 26 86  |  | 2b. HOUR<br>1:30 A.M.                        |  |
| 3. SEX<br>M  |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 31 11   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNKNOWN                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>UNKNOWN   |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1923 W. Mosher St 21217  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES GUNTER   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLOSSIE PHILLIPS   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN  |  | 16b. SOCIAL SECURITY NO.<br>225-18-7873  |  | 17. INFORMANT<br>ADDRESS<br>Jacqueline Gunter 1923 W. Mosher 21217  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAL ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                         |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><u>END STAGE SQUAMOUS CELL CARCINOMA OF LUNG</u>   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>9/15/86  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Prolonged mechanical ventilation   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>AUG 26</u> , 19 <u>86</u> , to <u>OCT 26</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>OCT 26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Bryan K. Bartle MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>10/26/86   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRYAN K. BARTLE MD  |  |  |  | 22e. ADDRESS<br>225. GREENE ST BALT MD 21201  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10-29-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James A. Morton + Sons   |  |  |  | ADDRESS<br>1701 Laurens ST.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1986  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

44-38861-01



00-22831

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 86 28194   |  | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>ISABEL M. GUNTHER  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 29 86  |  | 2b. HOUR<br>5 50 PM  |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 30 99   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENN.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>SOUTH BALTIMORE GENERAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MARYLAND   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JAMES M. MULLAN   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNIE AULT                           |  | 16. STREET ADDRESS / ZIP CODE<br>3838 ROLAND AVE 21211  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>220-24-8292  |  | 17. INFORMANT ADDRESS<br>JEAN SKLADOWSKY SEVERNA PKM  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Upper GI bleeding<br>DUE TO, OR AS A CONSEQUENCE OF (b) Peptic Ulcer disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Paralytic Ileus   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>② Pneumonia + Organic Brain Syndrome   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-26, 19-86, to 10-29, 19-86, that (I) (we) last saw the deceased alive on 10-29-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Patricia S Steadman  |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>10-29-86   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DHARMASENA K.   |  |  |  | 22e. ADDRESS<br>SOUTH BALTIMORE GENERAL HOSP  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11-1-86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Balto. Md.                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co., Balto., Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1986  |  | 25b. REGIS. OFFICE   |  |  |  |

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Hon. A. J. Jackson & Sons Co., Bankers, New York City.  
New York City, N. Y.  
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## MEDICAL CERTIFICATION

24 FUNERAL DIRECTOR

1620 Edmondson Ave Catonsville Md 21229

Ys. DATE RECD BY REGISTRAR

25b REGISTRAR'S SIGNATURE \_\_\_\_\_

OCT 27 1986

\_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

00-55131

2004 OCT 20 PM 4:18  
MAIL ROOM  
FBI - NEW YORK

0-20711

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the body be retained by the hospital or attending physician. The low requires that the body be retained by the hospital or attending physician. The low requires that the body be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please reprove carbonpapers, pages 1 and 2 should be attached to the death certificate. The funeral director should be notified of the death within 24 hours of the death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Thelma   |  | FIRST<br>U   |  | MIDDLE<br>V   |  | LAST<br>Guyton  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 7, 1986  |  | 2b. HOUR<br>12 30 PM                                     |  |
| 3. SEX<br>female  |  | 4. RACE<br>caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 8 12  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>DEATON HOSPITAL & MED. CENTER |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>homemaker.  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Howard  |  | 13c. CITY OR TOWN<br>Dorsey   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7010 Elm Ave. 21227   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Frantum  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna Kramer  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 32 5431   |  | 17. INFORMANT<br>Michael E. Guyton  |  |   |  | ADDRESS<br>7010 Elm Ave., Dorsey Md. 21227  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Aspiration pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hours |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>NIDDM - Hyperglycemia, Hypothyroidism   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from October 16, 1985, to October 7, 1986, that (I) (we) last saw the deceased alive on October 7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Melissa Friedland, MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>10/7/86   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Melissa Friedland  |  |  |  | 22e. ADDRESS<br>6415 S. Charles St. Baltimore   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  | 23b. DATE<br>10/10/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge, Md. Howard                              |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Gary L. Kaufman   |  |  |  | ADDRESS<br>5695 Main St., Elkridge, Md. 21227   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 10 1986  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

Handwritten notes and stamps, mostly illegible due to fading and bleed-through. Some visible words include "RECEIVED", "JAN 1941", and "U.S. DEPT. OF JUSTICE".

Handwritten notes at the bottom of the page, including "RECEIVED" and "JAN 1941".

00-21902

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28197  
REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES ECKLEY GWYNN, SR.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SATURDAY OCT 18 1986</b>                              |  | 2b. HOUR<br><b>7:35A M</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APR. 30, 1904</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3304 POWHATAN AVENUE</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>POST OFFICE</b>  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3304 POWHATAN AVE. 21216</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH GWYNN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CLARA MAE COUPLIN</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217 09 2440</b>  |   | 17. INFORMANT ADDRESS<br><b>MRS. BERTHA T. GWYNN 3304 POWHATAN AVENUE</b>                                  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Prostatic Adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/1</b> , 19 <b>85</b> , to <b>10/18/</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/1</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.      |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Marshall A. Levine</b>   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>10/20/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marshall A. Levine</b>  |  | 22e. ADDRESS<br><b>211 W. 40th St Baltimore, MD, 21211</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>10/23/86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEMETERY</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE (BALTO.) MD</b>                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>   |  |   | 25. DAY READ BY CLERK OR REGISTRAR<br><b>OCT 21 1986</b>  |  |  |
| ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>  |  |   |   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28198

1- FOR  
STATE  
REGISTRAR

|   |  |              |  |  |  |   |  |   |  |
|---|--|--------------|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mary Gwynn  |  |              |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>10-12 19 86                               |  |   |  | 2b. HOUR<br>12:01 a. M.   |  |
| 3. SEX<br>F   |  | 4. RACE<br>B |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 21 24  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>62 YRS.                               |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Us.a.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD  |  |              |  | 2c. DATE PRONOUNCED DEAD<br>10-12 19 86  |  |   |  | 2d. HOUR<br>12:01 a. M.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>unemp.   |  |
| 13a. STATE<br>Maryland  |  |              |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS<br>818 North Milton Avenue 21205  |  |              |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>David D. Chase   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lotty V. Denby   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |  |              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220220881   |  | 17. INFORMANT<br>ADDRESS<br>Winfield Gwynn 818 North Milton Avenue            |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |              |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br>Diabetes Mellitus   |  |              |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22a. I certify that I am in charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |              |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Charles P. Kokes  |  |              |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>10-12-86   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Charles P. Kokes, M.D.  |  |              |  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |              |  | 23b. DATE<br>10/17/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March Funeral Home Inc.  |  |              |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 16 1986                                  |  | 25b. REGISTRAR'S SIGNATURE  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 3. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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00-21909

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the funeral director. Pages 1, 2, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 86 28199   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>VIRGINIA V HADDAWAY   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10/20/86  |  | 2b. HOUR<br>0650 M   |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 20 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>74 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13c. STREET ADDRESS / ZIP CODE<br>1055 Maiden Choice Lane 21229  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Sands  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Angerona Sbis   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>220-48-2649   |  | 17. INFORMANT ADDRESS<br>Virginia Shockney 5524 Highridge St. 21227   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 10/18, 1986, to 10/20, 1986, that (we) last saw the deceased alive on 10/20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Steven Gruben   |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>10.20.86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GRUBEN   |  | 22e. ADDRESS<br>ST. AGNES HOSP, 900 Caton Ave Balto. Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10/23/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Dorsey Howard Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Ambrose, Inc. 1328 Sulphur Spr. Rd. 21227  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 2 - 1986   |  | 25b. REGISTRAR'S SIGNATURE   |  |

BP



00-21651

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

28200

FOR  
STATE  
REGISTRAR

|  |        |  |         |  |  |   |  |                          |  |            |      |                                 |          |  |
|--|--------|--|---------|--|--|---|--|--------------------------|--|------------|------|---------------------------------|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        | FIRST  |         | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH        |  | MONTH      | DAY  | YEAR                            | 2b. HOUR |  |
| Erman  |        |  |         |  |  | Hairston  |  | OCTOBER                  |  | 16         | 1986 | 8 <sup>38</sup> A.M.            |          |  |
| 3. SEX   | FEMALE |  | 4. RACE | BLACK  |  | 5. DATE OF BIRTH  |  | MONTH                    |  | DAY        | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) |          |  |
|  |        |  |         |  |  | 10/2  |  | 02                       |  | 84         |      | 52                              |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |        | 7b. CITIZEN OF WHAT COUNTRY?   |         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | Baltimore City           |  |            |      | MD.                             |          |  |
| 10. CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  | Unemp                    |  |            |      |                                 |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |        | 13b. COUNTY  |         | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS      |  | ZIP CODE   |      |                                 |          |  |
| N.Y.   |        | 13b. COUNTY  |         | Bronx  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5360 BROADWAY            |  | LANE 10463 |      |                                 |          |  |
| 14. FATHER'S NAME  |        | FIRST  |         | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME |  | FIRST      |      | MIDDLE                          |          |  |
| WILLIE   |        |  |         |  |  | BOOKER  |  | WILLIE                   |  |            |      | GARNER                          |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |        | 16b. SOCIAL SECURITY NO.   |         | 17. INFORMANT  |  | ADDRESS   |  |                          |  |            |      |                                 |          |  |
| NO (NO OR UNKNOWN)   |        | 422481367  |         | Nathaniel Booker   |  | 29 Fifth Ave.   |  |                          |  |            |      |                                 |          |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  | 2 HOURS                                      |  |
| IMMEDIATE CAUSE (a) MASSIVE ASPIRATION PNEUMONIA                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (b) SMALL BOWEL OBSTRUCTION   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c)   |  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|   |   |  |   |
|---|---|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
| N/A   | N/A   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |   |
|   | HOUR A.M. MONTH DAY YEAR  | N/A  |   |
|   | P.M. 19   |  |   |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION  |   |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | STREET CITY OR TOWN COUNTY STATE   |   |
|   |   | N/A  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 10/13, 1986, to 10/16, 1986, that (I) (we) last saw the deceased alive on 10/16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |
| 22b. SIGNATURE  | DEGREE  |  | 22c. DATE SIGNED  |
| Richard P. Franklin MD  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 10/17/86  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS  |  |   |
| RICHARD P. FRANKLIN   | The Union Memorial Hospital   |  |   |

|  |                               |                                    |                            |
|--|-------------------------------|------------------------------------|----------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE                     | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION              |
| BURIAL                                     | 10/24/86                      | Ft Custard VA Cem.                 | Fort Custard, Michigan     |
| 24. FUNERAL DIRECTOR                       | 25a. DATE REC'D. BY REGISTRAR |                                    | 25b. REGISTRAR'S SIGNATURE |
| NAME ADDRESS                               | OCT 21 1986                   |                                    |                            |
| March Funeral Homes 1101 East North Avenue |                               |                                    |                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 1B shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be prepared within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 6 2 8 2 0 1<br>REG. NO.  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BENJAMIN HALL   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 26 86   |  |  |  | 2b. HOUR<br>6:08 <sup>P</sup>  |  |  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 1 30  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                         |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                              |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Court Nurs. Hm. |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| 13a. STATE<br>Md.  |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br>1307 N. Charles St. 21218 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII  |  | 17. INFORMANT<br>ADDRESS   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cancer of Lungs<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Months |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/26, 19 86, to 9/29, 19 86, that (I) (we) last saw the deceased alive on 9/28/19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Richard Tyson, M.D.  |  |   |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>9/29/86                            |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Tyson, M.D.   |  |   |  | 22e. ADDRESS<br>936 W. North Avenue Balto., Md. 21217  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  | 23b. DATE<br>9-29-86  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |   |  | ADDRESS<br>Balto., Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 10 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Pandora   |  |  |  |  |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH THE DEATH CERTIFICATE. GIVE PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28202

FOR  
1- STATE  
REGISTRAR

|   |         |  |  |   |  |   |  |   |  |                          |  |   |  |      |  |  |  |
|---|---------|--|--|---|--|---|--|---|--|--------------------------|--|---|--|------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2b. DATE KNOWN OF DEATH MATED   |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR                                     |  |
| JOHN Leonard HALL   |         |  |  |   |  |   |  | 10 19 86  |  |                          |  |   |  |      |  | M  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD |  | MONTH   |  | DAY  |  | 2d. HOUR                                     |  |
| Male  | White   | March 16 1921  |  | 65  |  |   |  |   |  | 10 19 86                 |  |   |  |      |  | 12:41 P.M.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                          |  |   |  |      |  | MD.  |  |
| Maryland  |         | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  | Baltimore City  |  |                          |  |   |  |      |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |   |  |      |  |  |  |
| Baltimore   |         | Union Memorial Hospital                                  |  | Mechanic  |  | Balto. Transit  |  |   |  |                          |  |   |  |      |  |  |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                          |  |   |  |      |  |  |  |
| Md.   |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4627 Ababia Ave   |  |                          |  |   |  |      |  | 21214  |  |
| 14. FATHER'S NAME   |         | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE  |  | LAST                     |  |   |  |      |  |  |  |
| James F. Hall   |         |  |  |   |  | Catherine M. Flynn  |  |   |  |                          |  |   |  |      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         | (IF YES, GIVE WAR OR DATES)                              |  | 16b. SOCIAL SECURITY NO.                                      |  | 17. INFORMANT   |  | ADDRESS   |  |                          |  |   |  |      |  |  |  |
| Yes   |         | WW II  |  | 220-03-5613   |  | Theresa Karpovich   |  | 3511 Chesterfield Ave.  |  |                          |  |   |  |      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b).<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).  |         |  |  |   |  |   |  |   |  |                          |  |   |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |  |  |   |  |   |  |   |  |                          |  |   |  |      |  |  |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |  |   |  |                          |  | 20. AUTOPSY?  |  |      |  |  |  |
|   |         |  |  |   |  |   |  |   |  |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |      |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19    |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                          |  |   |  |      |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                          |  |   |  |      |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |   |  |                          |  |   |  |      |  |  |  |
| ACTUAL SIGNATURE  |         |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER            |  |   |  |   |  |                          |  | DATE SIGNED 10-20-86  |  |      |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |  |  | Charles P. Kokes, M.D.  |  |   |  |   |  |                          |  | ADDRESS 111 Penn St., Balto., MD 21201                              |  |      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |      |  |  |  |
| Burial  |         |  |  | 10-23-86  |  |   |  | Baltimore National  |  |                          |  | Baltimore Md.   |  |      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |         |  |  | ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |                          |  | 25b. REGISTRAR'S SIGNATURE  |  |      |  |  |  |
| Leonard J. Ruck, Inc.   |         |  |  | 5305 Harford Rd.  |  |   |  | OCT 21 1986   |  |                          |  |   |  |      |  |  |  |

March 10, 1938

Mr. J. A. [illegible]

Mr. J. A. [illegible]

Mr. J. A. [illegible]

Mr. J. A. [illegible]

Mr. J. A. [illegible]



Mr. J. A. [illegible]

Mr. J. A. [illegible]



10-20084

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 88 28203

|   |  |   |   |  |                       |  |
|---|--|---|---|--|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Wallace M. Hall   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 03 86 |  | 2b. HOUR<br>9:17 P.M. |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 21, 1909                                 |                       |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |   | 8. IF UNDER 24 HRS<br>HOURS MIN.   |                       |  |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Texas   |  | 9b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |                       |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Battery Repair    |                       |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br>Beth Steel  |  | 13a STATE<br>Maryland   |   | 13b COUNTY   |                       |  |
| 13c CITY OR TOWN<br>Baltimore   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e STREET ADDRESS / ZIP CODE<br>6205 Alta Ave. 21206                                |                       |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Martin M. Hall   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha Alma Long  |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes           |                       |  |
| 16b SOCIAL SECURITY NO.<br>1937   |  | 17 INFORMANT<br>Rose M. Hall  |   | ADDRESS<br>6205 Alta Ave. 21206  |                       |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Severe Metabolic/Respiratory Acidosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Ischemic Bowel</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Strangulated hernia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>COPD; SIP MR</u>   |  |   |   |  |                       |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                           |                       |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  | 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |                       |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a I certify that (I) (this hospital) attended the deceased from <u>9/11</u> , 19 <u>86</u> , to <u>10/3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/3</u> , 19 <u>86</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |   |  |                       |  |
| 22b SIGNATURE<br><u>Steven F. Crawford</u>  |  | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>10/3/86  |                       |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Steven F. Crawford, M.D.  |  | 22e ADDRESS<br>Union Memorial Hospital  |   |  |                       |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Oct. 6, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn                                       |                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk Balto., Md.   |  | 24. FUNERAL DIRECTOR<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214   |   |  |                       |  |
| 25a DATE REC'D. BY REGISTRAR<br>OCT 06 1986   |  | 25b REGISTRAR'S SIGNATURE<br><u>J. Davidson</u>   |   |  |                       |  |

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0-30084

RECEIVED  
MOTION PICTURE  
DIVISION  
JAN 10 1950

6150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, then this certificate must be filed with the medical examiner.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, then this certificate must be filed with the medical examiner.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 28204   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGARET HALL AMEYER</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 30 1986</b>   |  |   |  |
| 3 SEX<br><b>F</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 18 20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>65</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY MED</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MD BALTIMORE DUNDALK</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>GEORGE DE WARD</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY ELLEN FINN</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>21414 4263</b>   |  | 17. INFORMANT ADDRESS<br><b>MARGARET BOLLOCK 7023 EASTBROOK 21224</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE - CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ANTERIOR MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/26/86</b> 19 <b>86</b> to <b>10/30</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/30</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Joan Aug. C. L. MD</b>   |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>10/30/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOAO A C LIMA MD</b>  |  |   |  | 22e. ADDRESS<br><b>6A RAYLON DRIVE</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>11/1/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SECURITY PROCESS</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>CONNELLY FUNERAL HOME OF DUNDALK</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV - 6 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |

BP

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00-21127

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 8 2 0 5  
REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Verna L. Halstead   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10-14-86                                  |  | 2b. HOUR<br>5:45 P.M.  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH MONTH DAY YEAR<br>06 07 07   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS                                      | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Deaton Medical Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Walter  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elva O'Laughlin                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>219-10-4881   |   | 17. INFORMANT ADDRESS<br>Fred B. Halstead 3639 Glengyle Ave. 21215             |  |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure &amp; sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pressure ulcer, sacrum</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Dehydration</u>  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>22 July</u> 19 <u>86</u> to <u>14 Oct</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>14 Oct</u> 19 <u>86</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><u>J.W. Reed M.D.</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>10/15/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J.W. REED   |  | 22e. ADDRESS<br>6115 CHAS. ST. BALTIMORE 21230  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>10/18/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>A. Alan Seitz, Jr. 3818 Roland Ave. 21211  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 16 1986                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and appropriately filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner will file a report of cause.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28206

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |   | 7b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ROBIN HAMILTON.</b>  |  | 10/31/86  |   | 6 <sup>15</sup> P.M.  |  |
| 2. SEX <b>Female</b>   | 4. RACE <b>Black</b>   | 3. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)   | 8. IF UNDER 1 YEAR  |  |
|  |  | Sept. 17, 1959  | 27 YRS  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 1. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore MD</b>  |   |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hosp.</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>                      |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>  | 13b. COUNTY <b>P.G.</b>  | 13c. CITY OR TOWN <b>Capt. Hgts.</b>  | 13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <b>320 Shady Glen Drive 20743</b>                                |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>James Brown</b>   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Evelyn Ray</b>   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  | 16b. SOCIAL SECURITY NO. <b>578 84 1569</b>  | 17. INFORMANT ADDRESS <b>Albert R. Hamilton-husband-320 Shady Glen Drive, Capital Hgts. Md.</b> |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)   |  |   |   |   |  |
| PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Resp Arrest.</b>  |  |   |   |   |  |
| Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: <b>Leukemia, unresponsive to Tx.</b>  |  |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |   |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/31 86</b>                                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                             |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/31 86</b> to <b>10/31 86</b> , that (1) (we) last saw the deceased alive on <b>10/31 86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not use the body after death. |  |   |   |   |  |
| 22b. SIGNATURE <b>Guthrie</b>  |  | DEGREE  |   | 22c. DATE SIGNED <b>10/31/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Guthrie</b>   |  | 22e. ADDRESS <b>UMCC.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Nov. 5, 1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>                                 |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, Maryland</b>  |  |   |   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>John T. Stewart</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV - 6 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Julia Dinsmore Radner</b>   |  |
| 26. FUNERAL HOME ADDRESS <b>Stewart Funeral Home-4001 Benning Road, N.E.</b>   |  |   |   |   |  |

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23310 NOV-2-10

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10/10/10



00-21431

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRS 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7. DATE OF DEATH   |  | MONTH  |  | DAY   |  | YEAR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2b. HOUR                                       |  |
| ELLA   |  | M  |  | HAMMITT  |  | 10/14/86  |  | 7:25 P.M.                                      |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR                                |  |
| Female   |  | Black  |  | MONTH 4 DAY 18 YEAR 57   |  | 29 YRS.   |  | MONTHS DAYS HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| Maryland   |  | USA  |  |  |  | Baltimore City MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore  |  | University of Maryland   |  | unemployed   |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                 |  |
| MD   |  | Baltimore  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  | 330 E 20th St 21218                            |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                          |  |
| Samuel   |  | Susan  |  | Unknown  |  |   |  | Susan Hammit 330 E. 20th St 21218              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF                                    |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                    |  |  |  |
| (b) Seizure  |  | 5 min  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |
| (c) Autoimmune deficiency syndrome   |  | 15 min   |  |  |  |   |  |  |  |
| 6 mo   |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |   |  |  |  |
| 21a. DATE OF OPERATION   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                           |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                           |  |
|  |  | P.M. 19  |  |  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  | 21g. CITY OR TOWN   |  | 21h. COUNTY                                    |  |
|  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  |   |  | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/3/86 to 10/14/86, that (I) (we) lost  |  |  |  |  |  |   |  |  |  |
| saw the deceased alive on 10/14/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 22f. DATE REC'D BY REGISTRAR                   |  |
| Nadine B Semer MD  |  | 10/14/86   |  | Nadine B Semer MD  |  | Univ of MD Hospital 228 Greene St Balt MD   |  | OCT 16 1986                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D BY REGISTRAR   |  | 22g. REGISTRAR'S SIGNATURE  |  |  |  |
| Nadine B Semer MD  |  | Univ of MD Hospital 228 Greene St Balt MD  |  |  |  | Davidson-Rodella  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. STATE                                     |  |
| BURIAL   |  | 10-18-86   |  | MT. AUBURN CEM.  |  | BALTIMORE   |  | MD   |  |
| 24. FUNERAL DIRECTOR   |  | 24b. ADDRESS   |  | 24c. DATE REC'D BY REGISTRAR   |  | 24d. REGISTRAR'S SIGNATURE  |  |  |  |
| MARCH FUNERAL HOME   |  | 1101 E. North Ave.   |  | OCT 16 1986  |  | Davidson-Rodella  |  |  |  |

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

16415-00

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

1

00-20766

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28208

1- FOR  
STATE  
REGISTRAR

ROXANNE LAURA

1. DECEASED NAME  
(TYPE OR PRINT)

BABY GIRL BOYD (Hampers)

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

10 6 86 6<sup>56</sup> A.M.

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

9 26 86

6. AGE (IN YEARS LAST BIRTHDAY)

0 YRS.

IF UNDER 1 YEAR

MONTHS

IF UNDER 24 HRS

DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY MD.

12. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

FRANCIS SCOTTEKEY MED. CTR.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Infant

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Balto

13c. CITY OR TOWN

Balto

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4940 Eastern Ave, 21224

14. FATHER'S NAME

George

MIDDLE

LAST

Hampers

15. MOTHER'S MAIDEN NAME

LISA

MIDDLE

LAST

BOYD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO

17. INFORMANT

LISA Boyd

ADDRESS

746 ANNAPOLIS MCK RD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

SEVERE ASPHYXIA

DUE TO, OR AS A CONSEQUENCE OF

(b) CARDIORESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

NONE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/5/19 86 to 10/6/19 86 that (I) (we) lost saw the deceased alive on 10/6/19 86, and that in my (our) opinion death occurred on the date and hour and I am the causes stated above (I) (we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

M.D.

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

10/6/86

23a. PHYSICIAN'S NAME (TYPE OR PRINT)

STACEY A. HINDERLITER

23b. ADDRESS

FRANCIS SCOTTEKEY MED. CTR.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

OCT 8, 1986

23c. NAME OF CEMETERY OR CREMATORY

HILLcrest mem

23d. LOCATION

CITY OR TOWN

ANNAPOLIS

COUNTY

A.A. MD

24. FUNERAL DIRECTOR

C.E. Hicks III

25a. DATE REC'D. BY REGISTRAR

1922 forest Drive

25b. REGISTRAR'S SIGNATURE

ANNAPOLIS, MD

25c. DATE REC'D. BY REGISTRAR

OCT 14 1986

25d. REGISTRAR'S SIGNATURE

John D. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in the State Department of Health and Mental Hygiene, it should be furnished for use on the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-50780

40-50780

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

0

11



202° COTTON EIGHT

WATKINS

11

11

40-50780

#1 per M.E. 11/29/88 km  
STATE Film 645  
DISTRICT

023187 NOV 17 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28207

|  |                         |   |   |   |  |  |                             |   |  |
|--|-------------------------|---|---|---|--|--|-----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rudolph</b><br><b>RALPH</b>   |                         |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 22 19 86</b>  |  |  |                             | 2b. HOUR<br>AM <b>10:30</b>   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 11 12</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74 YRS.</b> | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN | 9. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>10 25 19 86</b>                         | 2d. HOUR<br>AM <b>10:30</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>524 N. Charles St.</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder</b>       |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Coast Guard</b>                             |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             | 13e. STREET ADDRESS<br><b>524 N. Charles St. 21201</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Handel</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara</b>   |  |  |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>705-03-7262</b>  |   | 17. INFORMANT ADDRESS<br><b>41 Nicholson Dr. Ms. Michelle Schwartzman Pasadena, Md.</b>   |  |  |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |                         |   |   |   |  |  |                             |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |   |   |   |  |  |                             |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |  |                             | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |                             |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                             |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |   |   |  |  |                             |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |                         | TITLE (SPECIFY)<br><b>M.D. Assistant</b> MEDICAL EXAMINER   |   |   |  |  |                             | DATE SIGNED <b>10-25-86</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>   |                         | ADDRESS<br><b>111 Penn St., Balto., MD 21201</b>  |   |   |  |  |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |                         | 23b. DATE<br><b>10-29-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                             |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |                         |   |   | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 05 1986</b>                                  |                             | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                         |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

2025-01-17 10:00 AM



00-21975

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved in by the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 5 2 3 2 1 0

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |  |                                  |   |  |  |  |
|--|--|---|---|--|----------------------------------|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <del>XXXXXXXX</del> ANNE <i>Handwerker</i>  |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br>10-19-86   |  |                                  | 2b HOUR<br>3:15 PM  |  |  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>CAUCASIAN   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>UNOBTAINABLE  |                                  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 <del>XX</del> <del>XX</del> YRS.   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>XX MARYLAND  |  | 7b CITIZEN OF WHAT COUNTRY?<br>X U.S.A.   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |                                  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Balto City</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Levindale</i> |   |  |                                  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>bookkeeper</i>                            |  | 12b KIND OF BUSINESS OR INDUSTRY<br><i>ACCOUNTING</i>  |  |
| 13a STATE<br><i>md</i>   |  |   | 13b COUNTY<br><i>---</i>  |  | 13c CITY OR TOWN<br><i>Balto</i> |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>SAMUEL</i> <i>---</i> <i>HANDWERGER</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><i>REBECCA</i> <i>---</i> <i>WEINBERG</i> |  |                                  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO, XXXXXXXX |  |  |  |
| 16b SOCIAL SECURITY NO.<br><i>217-03-3549</i>  |  |   | 17 INFORMANT<br><i>CHS</i>  |  |                                  | 18 ADDRESS<br>MRS. MARIAN LEVY APT. B (21209)<br>3018 FALLSTAFF MANOR CT.                                       |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) }<br>DUE TO, OR AS A CONSEQUENCE OF (c) }                              |  |   |   |  |                                  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |  |                                  |   |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |                                  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                  |   |  |  |  |
| 21d INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/><br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                  |   |  |  |  |
| 22a. I certify that <i>X</i> (this hospital) attended the deceased from <i>10/19</i> 19 <i>86</i> , to <i>10/19</i> 19 <i>86</i> , that <i>A</i> (we) last saw the deceased alive on <i>10/19</i> 19 <i>86</i> , and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>(we)</i> (did) (take) view the body after death. |  |   |   |  |                                  |   |  |  |  |
| 22b SIGNATURE<br><i>E. Estrelita</i>   |  |   |   | DEGREE<br><i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                  |   |  | 22c. DATE SIGNED<br><i>10/20/86</i>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ESTRELITA O. KU</i>   |  |   |   | 22e ADDRESS<br><i>LOVINGDALE HEBRON GERIATRIC CENTER + HOSPITAL</i>  |                                  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>XXXXXX BURIAL</i>   |  | 23b DATE<br><i>10/21/86</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SHAAREI ZION CEM</i>  |                                  | 23d. LOCATION<br><i>ROSEDALE</i> <i>BALTO</i> STATE <i>MD</i>   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>SOL LEVINSON &amp; BROS., INC.</i><br><i>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</i>   |  |   |   | 25a DATE REC'D. BY REGISTRAR<br><i>OCT 23 1986</i>   |                                  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

BP

00-57852

✓  
EX-100  
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00-210813

FOR  
STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28211  
REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JELIA HARDY</b>    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 10 86</b>                                     |   | 2b. HOUR<br><b>1:45 PM</b>                                    |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 9 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA</b>                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Liberty Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(NATURE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic work</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. STATE<br><b>md</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BAITO</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS - ZIP CODE<br><b>111 CENTRE ST. 21201</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES HARDY</b>                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LIZZIE HARDY</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> | 16b. SOCIAL SECURITY NO.<br><b>320-14-2698</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Josephine MORTON 1316 Edison Hy.</b>                        |   |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory Failure</b>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory distress Syndrome</b>   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION<br><b>10/2/86</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Colon Cancer</b>      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) this Hospital attended the deceased from <b>9/21/86</b> to <b>10/10/86</b> that (I) we last saw the deceased alive on <b>10/10/86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) we (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Z. M. LAHITI</b>   | DEGREE   | 22c. DATE SIGNED<br><b>10/10/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Z. M. LAHITI</b>  | 22e. ADDRESS<br><b> Lutheran Hospital<br/>(Liberty Medical Center) Balto</b> |  |   |

|  |                              |  |  |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                      | 23b. DATE<br><b>10/14/86</b> | 23c. NAME OF CEMETERY OR CREMATOR<br><b>BALTIMORE Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. md</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>CHATMAN-HARRIS FH 1701 McCulloh St.</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>        | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>               |

CO-51083

10/10/50

10/10/50

2023 COLL

10/10/50

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10/10/50

00-22127

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28212

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 10 25 86   |  | 5 55 AM   |  |
| Katherine Hare  |  |   |  |  |  |   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female  |  | White   |  | June 22 15   |  | 71  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland  |  | USA   |  |  |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore   |  | Jenkins Memorial Home<br>1600 S. Caton Ave. 21229   |  | Office Clerk   |  | Dept. Store   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS  |  |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  | 1000 S. Caton Avenue, 21229  |  |   |  |
| Charles Weidenhammer  |  | Caroline Link   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |
| No  |  | 212-34-8101   |  | Virginia Upton,  |  | 1721 Wilson Road  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>MULTIPLE SCLEROSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 DAY</u><br><u>13 YRS</u> |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
|   |  |   |  |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>3-21</u> , 19 <u>85</u> , to <u>10-25</u> , 19 <u>86</u> , that (we) lost <u>saw the deceased alive on 10-25</u> , 19 <u>86</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |
| <u>John F. Hartman, M.D.</u>  |  |   |  |  |  | 10-25-86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |  |   |  |
| JOHN F. HARTMAN, M.D.   |  | JENKINS N.H. 1000 S. CATON AVE. BALTO. MD 21229   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial  |  | 10/28/86  |  | Loudon Park Cemetery   |  | Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Hubbard Funeral Home, Inc.,   |  | 21229 4107 Wilkens Ave.   |  | OCT 27 1986  |  |   |  |

BP



00-20830

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 8 2 1 3  
REG. NO.

|   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>TALMADGE W. HARPER   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 11, 1986 |  |  | 2b. HOUR A<br>1:43 M  |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 27, 1935  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51<br>YRS.   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chessie Railroad System |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Reisterstown  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clayton Harper  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JAUNITA FALLS   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>230-38-4214  |  | 17. INFORMANT<br>Ms. Kathryn Harper  |  |   |  | ADDRESS<br>Reisterstown, Md.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary Artery Disease</u>  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>20 min</u><br><u>2 days</u><br><u>5 yrs</u>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><u>NONE</u>  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>NONE</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>—</u>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><u>—</u>   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>—</u>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>—</u>  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/10</u> , 19 <u>86</u> , to <u>10/11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>San C. Harrison</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>10/11/86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Jan Harrison</u>  |  |   |  | 22e. ADDRESS<br><u>Johns Hopkins Hospital</u><br>600 N. WOLFE ST. BALTO., MD 21205   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/13/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Finksburg, Md.                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>Eline Funeral Home Reisterstown, Md. 21136  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>OCT 14 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated with the body within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and signed and filed in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, then the physician must be notified at once.

MEDICAL CERTIFICATION

1954

ATINUA

220-38-054

SECTION 101

1954

0-22934

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP

DHMH - 17  
(FOR VITALS ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28214

|  |   |   |                                      |   |  |
|--|---|---|--------------------------------------|---|--|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH   |                                      | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | 2a. DATE KNOWN OF DEATH   |                                      | 2b. HOUR  |  |
| FIRST MIDDLE LAST  |   | MONTH DAY YEAR  |                                      | M P M   |  |
| Connie Harrell   |   | 10/30/19 86   |                                      | 1:40  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)      | 7. IF UNDER 24 HRS.   | 8. DATE PRONOUNCED DEAD                      |
| F  | B   | 8/22/28   | 58 YRS.                              | MONTHS DAYS HOURS MIN.  | 10/30/19 86                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>         | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| Green County, N.C.   | U.S.A.  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                            | Baltimore City, MD.                  |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                 | 12b. KIND OF BUSINESS OR INDUSTRY    |   |  |
| Baltimore  | University Hospital Shock Trauma  | Evanglist   |                                      |   |  |
| 13a. STATE   | 13b. CITY OR TOWN   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13d. STREET ADDRESS                  |   |  |
| Hamden   | Hamden, Ct  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           | 12 Violet St 99999                   |   |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |                                      |   |  |
| O Dell Smith   | Annie Joyner  | no  |                                      |   |  |
| 16a. SOCIAL SECURITY NO.   | 17. INFORMANT   | ADDRESS   |                                      |   |  |
| 041-28-2847  | Norcott Funeral Home  | 711 S. Lee St   |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |   |                                      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY:  |   |   |                                      |   |  |
| IMMEDIATE CAUSE (a) Multiple Injuries with complications   |   |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |                                      |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:  |   |   |                                      |   |  |
| (b)  |   |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |                                      |   |  |
| (c)  |   |   |                                      |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |   |   |                                      |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                      | 20. AUTOPSY?  |  |
|  |   |   |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY   |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                   |                                      | 21f. LOCATION   |  |
| roadway  |   | I-95 & Rt. 295  |                                      | Pr. Geo., Md.   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |   |                                      |   |  |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)   |                                      | DATE SIGNED   |  |
| Margarita A. Korell, M.D.  |   | Assistant   |                                      | 10/31/86  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS   |                                      |   |  |
| Margarita A. Korell, M.D.  |   | 111 Penn St.  |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |   | 11-3-86   |                                      | Red Hill Cem.   |  |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR   |                                      | 25b. REGISTRAR'S SIGNATURE  |  |
| NAME ADDRESS   |   | NOV 3 - 1986  |                                      | Julia Forder-Randall  |  |
| Leroy O. Dyett & Son   |   | 4600 Liberty  |                                      |   |  |

43835-0

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10/10/10





00-21286

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28215  
R. NO.

|   |  |   |   |  |
|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>ANNIE RUTH HARRIS   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 15 86   |   | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 11 1922   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>64 YRS  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Ga  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                           |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>303 Lynhurst Street |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Disabled                    | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>303 Lynhurst Street 21229                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Fortson  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Blackwell  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-20-3018  |   | 17. INFORMANT<br>ADDRESS<br>Spencer Harris 303 Lynhurst Street                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks</u>                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Pt's Decision to stop Dialysis</u>  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 19, 86</u> to <u>October 19, 86</u> , that (I) (we) last saw the deceased alive on <u>September 28, 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |   |   |  |
| 22b. SIGNATURE<br><u>Jeffrey W. Posner, MD</u>  |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>10/16/86   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeffrey W. Posner, MD  |  | 22e. ADDRESS<br>1818 Pot Spray Rd Lutherville MD  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   | 23b. DATE<br>10/17/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Cemetery   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Md                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C. March F/ H West   |  | ADDRESS<br>4300 Wabash Avenue   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1986   |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |   |  |

MEDICAL CERTIFICATION

29

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

21535 20

00-8157



00-20693

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28216  
REG. NO.

|  |  |   |  |  |  |  |   |  |  |
|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EARLE HARRIS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 07 86</b>                 |  |  | 2b. HOUR<br><b>6:22 PM</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 25 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE<br>(COUNTRY) <b>WASH. DC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LINCOLN CONVALESCENT CENTER LABOR</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>21223</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES HARRIS</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IRENE LEE</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Army</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>#1217</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CANCER OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9/12 86</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET<br><b>9/12 86</b>                                      |  | CITY OR TOWN<br><b>10/07 86</b>                             |  | STATE  |
| 22a. I certify that (I) (the hospital) attended the deceased from<br>saw the deceased alive on <b>10/17 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Kuang-Yen Huang</b>   |  |   | DEGREE<br><b>MD</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>10/18/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>  |  |   | 22e. ADDRESS<br><b>BON SECOURS Hospital</b>                            |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE<br><b>10/18/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EASTVIEW men. OK</b>                  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>BALTO.</b> COUNTY STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BETH'S FUNERAL HOME</b> ADDRESS<br><b>1125 N. CAROLINE</b>  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1986</b>                            |  | 25b. REGISTRAR'S SIGNATURE                                  |  |  |

BP

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0-2153

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CHILDREN

00-21261

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28218  
REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>LILLY FLORENCE HARRIS  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>10 - 16 - 86  |  | 2b HOUR<br>0330A   |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>BLACK   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>03 08 25  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MD. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                         |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br>Home   |  | 13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b COUNTY<br>BALTO, MD.             |  |  |  |
| 13c CITY OR TOWN<br>BALTO, MD.   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  | 13e STREET ADDRESS / ZIP CODE<br>1943 POMETACON DRIVE 21076  |  |
| 14 OTHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES JOHNSON  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MATHILDA PARKER   |  | 16 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  |
| 16b SOCIAL SECURITY NO.<br>NONE  |  | 17 INFORMANT<br>WILLIE HARRIS 1943 POMETACON DRIVE  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CANCER OF VULVA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CONGESTIVE HEART FAILURE</u>   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |  |  |
| 9a DATE OF OPERATION<br>6/9/86   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CANCER OF VULVA  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |  |
| 21d INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>9-3</u> , 19 <u>86</u> , to <u>10-16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10-15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b SIGNATURE<br>BTymkin MD.   |  | DEGREE  |  | 22c DATE SIGNED<br>10/16/86  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>BARBARA TYMKIN   |  | 22e ADDRESS<br>UNIVERSITY OF MARYLAND   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b DATE<br>10/21/86  |  | 23c NAME OF CEMETERY OR CREMATORY<br>SAINT REST CEM.   |  |
| 23d LOCATION<br>CITY OR TOWN<br>ANNE ARUNDEL, MD.  |  | 23e COUNTY STATE  |  |  |  |
| 24 NAME OF FUNERAL HOME, INC.<br>2501 GWYNNS FALLS PKWY. BALTO, MD. 21216  |  | 25a DATE REC'D. BY REGISTRAR<br>OCT 17 1986   |  | 25b REGISTRAR'S SIGNATURE<br>[Signature]   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

BP

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10 - 10 - 1934

WILL FORD HARRIS

WHITE BLACK

05 08 12

41

BALTIMORE CITY

BALTIMORE UNIVERSITY OF MD

AND CITY

CHARLES

JOHNSON

RENAL FAILURE

CANCER OF UTERA

CONGESTIVE HEART FAILURE

CANCER OF UTERA

4/1/64

10-10-34

4-3

10-12

10/10/60

ST. JOHNS HOSP

UNIVERSITY OF MARYLAND

BALTIMORE THAILIN

PAUL BRIDGES

NOTED



00-22966

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28219  
REG. NO.

|  |  |  |  |  |  |  |   |   |   |  |
|--|--|--|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Louis Harthausen</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-31-86</b>                 |  |  | 2b. HOUR<br><b>5am</b> M   |   |   |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-1-1914</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3440 Cardenas Avenue</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Car Man</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3440 Cardenas Avenue 21213</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Harthausen</b>   |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith O'Reilley</b>         |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-03-5958</b>                         |  | 17 INFORMANT<br>ADDRESS<br><b>Rose Harthausen 3440 Cardenas Avenue 21213</b>   |  |   |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>b) <b>Myo cardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) <b>Diffuse athero-sclerosis</b><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a)<br><b>Insulin dependent diabetes.</b> |  |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>12 h</b>  |   |  |
|  |  |  |  |  |  |  |   | <b>12 h</b>   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 19 86</b> to <b>10/31 19 86</b> , that (I) (we) last saw the deceased alive <b>10/17 19 86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Dr. Disharoon</b>   |  |  |  |  | DEGREE<br><b>M.D.</b>  |  |   | 22c. DATE SIGNED<br><b>10/31/86</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Disharoon</b>  |  |  |  |  | 22e. ADDRESS<br><b>Brehms Medical Center<br/>Brehms Lane, Balto, Md. 21213</b> |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>11-3-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SCHIMUNEK FUNERAL HOME, Balto, Md. 21213</b>   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1986</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Tondor-Rudner</b>  |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

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1- STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28220  
REG. NO.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DR. Thomas G Hartley   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 1, 1986                      |  | 2b. HOUR<br>4:50 AM  |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 29 01  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                            |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore MD   | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>DEACON MD CENTER |  | 13a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dentist |  | 13b. KIND OF BUSINESS OR INDUSTRY<br>Self Employed                 |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br>Maryland Baltimore   | 15. CITY OR TOWN<br>Baltimore   | 16. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 17. STREET ADDRESS / ZIP CODE<br>3716 Lochearn Dr. Baltimore, MD. 21207     |  |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES W. HARTLEY  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MINNA SCHLINKMAN   |  | 20. ADDRESS<br>3716 Lochearn Dr. Balto., MD. 21207                          |  |  |
| 21a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 21b. SOCIAL SECURITY NO.<br>214-38-6428  |   | 21c. INFORMANT<br>Mrs. Mildred Hartley   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Multiple Decubiti<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Alzheimer's Dementia |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25, 1986, to 10/1, 1986, that (I) (we) lost<br>saw the deceased alive on 10/1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |
| 22b. SIGNATURE<br>Valerie Barnwell MD   |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>10/1/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Valerie Barnwell   |   | 22e. ADDRESS   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |   | 23b. DATE<br>10/2/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Baltimore, MD.   |   | 23e. TO BE READ BY REGISTRAR   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, MD. 21133  |   | 25. REGISTRAR'S SIGNATURE  |   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24-hour office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 28221

1- FOR  
STATE  
REGISTRAR

|   |         |  |  |   |  |   |  |  |  |                        |  |   |  |                         |  |   |  |
|---|---------|--|--|---|--|---|--|--|--|------------------------|--|---|--|-------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED  |  | MONTH                  |  | DAY   |  | YEAR                    |  | 2b. HOUR  |  |
| RANDOLPH  |         | David  |  | HARVEY  |  |   |  |  |  | 10                     |  | 25  |  | 1986                    |  | M   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE<br>PRONOUNCED<br>DEAD   |  | MONTH                  |  | DAY   |  | YEAR                    |  | 2d. HOUR  |  |
| Male  | White   | 3 27 67  |  | 19 YRS.   |  |   |  | 10   |  | 25                     |  | 1986  |  | 3P                      |  | M   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |                        |  |   |  |                         |  |   |  |
| Maryland  |         | United States  |  |   |  | Baltimore City  |  |  |  |                        |  |   |  |                         |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |  |  |                        |  |   |  |                         |  |   |  |
| Baltimore   |         | University Hospital (STU)  |  | Apprentice - Royal Electric   |  |   |  |  |  |                        |  |   |  |                         |  |   |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |  |                        |  |   |  |                         |  |   |  |
| Maryland  |         | Baltimore  |  | Catonsville   |  |   |  | 1318 Black Friars Road 21228   |  |                        |  |   |  |                         |  |   |  |
| 14. FATHER'S NAME   |         | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE   |  | LAST                   |  |   |  |                         |  |   |  |
| Billy   |         | Joe  |  | Harvey  |  | Linda   |  |  |  | Dease                  |  |   |  |                         |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT   |  | Mr. & Mrs. Tony Protani   |  | 21228  |  | 1318 Black Friars Road |  | Catonsville, MD.  |  |                         |  |   |  |
| no  |         | -----  |  | 215-58-3041   |  |   |  |  |  |                        |  |   |  |                         |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Blunt trauma to chest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |  |  |   |  |   |  |  |  |                        |  |   |  |                         |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |  |   |  |  |  |                        |  |   |  |                         |  |   |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |                        |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                         |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR<br>1:55 P.M. 10-25-1986   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Operator of motorcycle/fixed object impact. |  |                        |  |   |  |                         |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>road  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Greenspring Ave. &, Balto. MD<br>Evesprings Rd.                         |  |                        |  |   |  |                         |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |  |  |   |  |   |  |  |  |                        |  |   |  |                         |  |   |  |
| ACTUAL<br>SIGNATURE   |         |  |  | Dennis F. Smyth, M.D.<br>Assistant MEDICAL EXAMINER   |  |   |  |  |  |                        |  |   |  | DATE<br>SIGNED 10-26-86 |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         |  |  | 111 Penn St., Balto., MD 21201  |  |   |  |  |  |                        |  |   |  |                         |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                         |  |   |  |
| Burial  |         |  |  | 10/29/86  |  |   |  | Lorraine Park Cemetery   |  |                        |  | Baltimore Baltimore MD.   |  |                         |  |   |  |
| 24. FUNERAL DIRECTOR  |         |  |  | Loring Byers Funeral Directors, Inc.  |  |   |  | DATE REC'D. BY REGISTRAR   |  |                        |  | 25. REGISTRAR'S SIGNATURE   |  |                         |  |   |  |
| 8728 Liberty Road   |         |  |  | Randallstown, MD. 21133   |  |   |  | OCT 27 1986  |  |                        |  |   |  |                         |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGINS OF PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3, RETURN, PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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13582-00

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                               |  |  |  |  |  |  |  |                                |  | 28222   |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|--|--|--------------------------------|--|---|--|--|--|
| 1- FOR Film Film G621 item 18-22 REGISTRAR 11/13/86 rja   |  |                               |  |  |  |  |  |  |  |                                |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILLIAM GEORGE HATHEWAY</b>   |  |                               |  |  |  |  |  |  |  |                                |  | 2b. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR<br><b>10 24 19 86</b> |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 7, 1968</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>18 YRS.</b>  |  | 7. IF UNDER 1 YR. MONTHS DAYS  |  | 7. IF UNDER 24 HRS. HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR HOUR<br><b>October 10 24 19 86 10:30 AM</b>                      |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Attendant</b>  |  |                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gas Station</b>   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                               |  |  |  |  |  |  |  |                                |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>A A Co.</b> |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>138 Dorchester Road 21061</b>  |  |                                |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albion G. Hatheway, Jr.</b>  |  |                               |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Patricia A. Herold</b>                   |  |  |  |                                |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                               |  | 16b. SOCIAL SECURITY NO.<br><b>220.98.0742</b>   |  | 17. INFORMANT (Mother) ADDRESS<br><b>Patricia A. Baer Same As #13</b>                        |  |  |  |                                |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cocaine Intoxication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                               |  |  |  |  |  |  |  |                                |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I  |  |                               |  |  |  |  |  |  |  |                                |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |                                |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9:00 P.M. 10- 24 19 86</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Subject used Drug</b>  |  |                                |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1603 Poplin ST Baltimore Maryland</b>  |  |                                |  |   |  |  |  |
| 22a. I certify that took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |                               |  |  |  |  |  |  |  |                                |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  |                               |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER   |  |  |  |  |  |                                |  | DATE SIGNED <b>10-25-86</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>   |  |                               |  | ADDRESS <b>111 Penn St., Balto., MD 21201</b>  |  |  |  |  |  |                                |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                               |  | 23b. DATE<br><b>Oct 28, 1986</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>  |  |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A A co. Md.</b>                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Singleton Funeral Home Glen Burnie, Maryland</b>   |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1986</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |                                |  |   |  |  |  |

07/84  
25M

BP 343  
DHMH - 17  
(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 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and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |  |   |   |   |  |   |  |  |
|--|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ethel June HAUF   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 15, 1986     |   |   | 2b. HOUR<br>9:30 A.M.  |   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 19, 1927  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BEATON MEDICAL CENTER - SOUTH |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Lady       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Clothing Stores   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  |  | 13c. CITY OR TOWN<br>Pasadena                               |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>6 Fleetwood Court 21122 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter Wytowich  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maude Gary |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NA  |   | 17. INFORMANT (Husband)<br>Mr. Joseph A. Hauf   |   | ADDRESS<br>605 Brookwood Road<br>Baltimore, Md. 21229                                |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of Colon with Metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES, MEMBRUS</u>  |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>02/23</u> , 19 <u>86</u> , to <u>10/15</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>10/15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Michael J. Collins, MD</u>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>10/15/86   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   | 22e. ADDRESS  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Oct 18, 1986  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Park A A Co. Md.              |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>R. A. Hopkins  |  |  |   | ADDRESS<br>Singleton Funeral Home Glen Burnie, Maryland   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1986   |   | 25b. REGISTRAR'S SIGNATURE   |  |

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHA. 28224  
REG. NO.

|  |  |  |  |   |   |   |   |  |                  |  |
|--|--|--|--|---|---|---|---|--|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>EMMA BEATRICE HAUGHT<br>Emma Beatrice Haught                                       |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 6 10 24 86 |   |   | 2b. HOUR<br>12 <sup>30</sup> PM   |   |  |                  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 27 22  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                             |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, MD   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of MD Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER           |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME    |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>WEST VA. |  |  | 13b. COUNTY<br>HAMPSHIRE                         |   | 13c. CITY OR TOWN<br>ROMNEY                         |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 14. FATHER'S NAME<br>Edward  |  |  | 15. MOTHER'S MAIDEN NAME<br>Debra                |   |   | 16. STREET ADDRESS / ZIP CODE<br>9900 N. GRAFTON STREET 26757<br>HERITAGE VILLAGE APTS. |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>433-38-0234          |   | 17. INFORMANT<br>DEBRA WATSON ROMNEY, WEST VIRGINIA |   |   |  | ADDRESS<br>26757 |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediately</u>                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Myelogenous Leukemia, Blast phase</u> |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>appt. chm.r.</u>                              |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Significant budding diathesis secondary to thrombocytopenia

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 1</u> , 19 <u>86</u> , to <u>October 24</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>October 24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Michael H. Weiss MD</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>10/24/86</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Michael H. Weiss, MD.</u>   |  |  |  | 22e. ADDRESS<br><u>University of MD Hospital Baltimore</u>   |  |  |  |

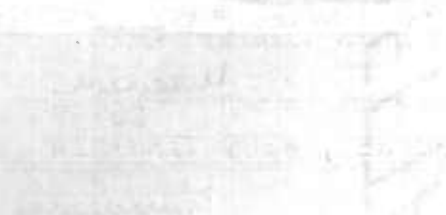
|  |  |                           |  |   |  |  |  |
|--|--|---------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                      |  | 23b. DATE<br>OCT. 27, '86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WADESTOWN CEMETERY WADESTOWN, WEST VIRGINIA |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD. |  |                           |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>OCT 27 1986           |  |  |  |

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00-21813

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28225

|   |  |   |   |   |   |  |  |
|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GEORGE B HAWKINS  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 18 86 |   |   | 2b. HOUR<br>2:00 PM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 26 15   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC BALTIMORE, MARYLAND 21218 |   |   |   | 12a. USUAL OCCUPATION<br>(IF WORK FOR MOST OF WORKING LIFE)<br>Chauffeur |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |   |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD  |  |   |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Balto.  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   | 13e. STREET ADDRESS / ZIP CODE<br>2249 Eutaw Pl. 21217  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE HAWKINS JR.  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MABEL HENSON   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES  |  |   |   | 16b. SOCIAL SECURITY NO.<br>212 01 0594   |   | 17. INFORMANT<br>ADDRESS<br>John Hawkins - 1727 N. Smallwood             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic Lung Cancer<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5m10   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>OCTOBER 14</u> , 19 <u>86</u> , to <u>OCTOBER 18</u> , 19 <u>86</u> , that (I/we) last saw the deceased alive on <u>OCTOBER 18</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death. |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br>Barditch  |  |   |   | DEGREE  |   | 22c. DATE SIGNED<br>10/20/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BARDITCH   |  |   |   | 22e. ADDRESS<br>Loch Raven VA Hosp  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  | 23b. DATE<br>10-24-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD             |  |
| 24. FUNERAL DIRECTOR<br>March F/H 1101 E. North Ave.  |  |   |   | 25a. DATE OF DEATH<br>OCT 23 1986   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |   |   |   |   |  |  |

MEDICAL CERTIFICATION

BP

Handwritten notes and diagrams, including a large rectangular box with internal lines and a small square box with a diagonal line.



US - Health  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
b7c086 0110  
21289  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician, and retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be signed and dated.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 8 REG NO.  |  | 2 8 2 2 0   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>KENNETH V HAWTHORNE SR.  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 16, 1986  |  | 2b. HOUR MIN<br>9:10 M  |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 <sup>TH</sup> 30 1941  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                         |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (GIVE ONLY LAST NAME OF WORKING LIFE)<br>Machinist          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Can Co.  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br>Maryland Baltimore Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>5716 Utrecht Rd. 21206                          |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph V. Hawthorne   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Thelma Mason  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>223-54-3047  |  | 17. INFORMANT ADDRESS<br>Mrs. Donna Hawthorne 5716 Utrecht Rd. 21206  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>857<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sulfonamide Toxicity</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>one minute<br>20 years<br>33 years |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Liver Failure, Chronic Hepatitis B, Immunosuppression</u>  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>86</u> , to <u>10/15</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased <u>die</u> on <u>10/16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE DEGREE<br><u>D L Clemens, MD PhD</u>  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br>10/16/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D L Clemens, MD PhD   |  |  |  | 22e. ADDRESS  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/19/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>White Stone Meth.Ch.Cemt.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>White Stone Lancaster Va.              |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT. 17 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                  |  |   |  |





00-22129

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 8 2 8 2 2 1  
REG. NO.

|  |  |   |   |   |  |  |   |  |
|--|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROSE Boyajian HAYES                 |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 25, 1986 |   |  | 2b. HOUR<br>10:15 A <sup>M</sup>   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 16, 1928  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS                                      |   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>New York                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Proprietor |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bookstore |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Mihran Boyajian                  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Roxy Essayian  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  |   | 16b. SOCIAL SECURITY NO.<br>231-20-7260                 |   | 17. INFORMANT<br>ADDRESS<br>Agnes M. Solline 15630 Thornbrook Drive Houston, Texas 77084 |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) CARDIO PULMONARY ARRESTAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

10 minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Breast Cancer

4 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>86</u> , to <u>10/25</u> , 19 <u>86</u> , that (we) lost<br>saw the deceased alive on <u>10/25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Raymond N. DuBois MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/25/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Raymond N. DuBois  |  |  |  | 22e. ADDRESS<br>Johns Hopkins Hospital   |  |   |  |

|   |  |                         |  |   |  |  |  |
|---|--|-------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                       |  | 23b. DATE<br>10/27/1986 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley, Inc. 2135 Dundalk Avenue |  |                         |  | 25a. DATE REC'D BY REGISTRAR<br>OCT 27 1986                 |  | 25b. REGISTRAR'S SIGNATURE                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene (Pratt Building, Baltimore, Maryland). The medical examiner, if any, must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 24 27 30 33 36 39 42 45 48 51 54 57 60 63 66 69 72 75 78 81 84 87 90 93 96 99 102 105 108 111 114 117 120 123 126 129 132 135 138 141 144 147 150 153 156 159 162 165 168 171 174 177 180 183 186 189 192 195 198 201 204 207 210 213 216 219 222 225 228 231 234 237 240 243 246 249 252 255 258 261 264 267 270 273 276 279 282 285 288 291 294 297 300 303 306 309 312 315 318 321 324 327 330 333 336 339 342 345 348 351 354 357 360 363 366 369 372 375 378 381 384 387 390 393 396 399 402 405 408 411 414 417 420 423 426 429 432 435 438 441 444 447 450 453 456 459 462 465 468 471 474 477 480 483 486 489 492 495 498 501 504 507 510 513 516 519 522 525 528 531 534 537 540 543 546 549 552 555 558 561 564 567 570 573 576 579 582 585 588 591 594 597 600 603 606 609 612 615 618 621 624 627 630 633 636 639 642 645 648 651 654 657 660 663 666 669 672 675 678 681 684 687 690 693 696 699 702 705 708 711 714 717 720 723 726 729 732 735 738 741 744 747 750 753 756 759 762 765 768 771 774 777 780 783 786 789 792 795 798 801 804 807 810 813 816 819 822 825 828 831 834 837 840 843 846 849 852 855 858 861 864 867 870 873 876 879 882 885 888 891 894 897 900 903 906 909 912 915 918 921 924 927 930 933 936 939 942 945 948 951 954 957 960 963 966 969 972 975 978 981 984 987 990 993 996 999 1002 1005 1008 1011 1014 1017 1020 1023 1026 1029 1032 1035 1038 1041 1044 1047 1050 1053 1056 1059 1062 1065 1068 1071 1074 1077 1080 1083 1086 1089 1092 1095 1098 1101 1104 1107 1110 1113 1116 1119 1122 1125 1128 1131 1134 1137 1140 1143 1146 1149 1152 1155 1158 1161 1164 1167 1170 1173 1176 1179 1182 1185 1188 1191 1194 1197 1200 1203 1206 1209 1212 1215 1218 1221 1224 1227 1230 1233 1236 1239 1242 1245 1248 1251 1254 1257 1260 1263 1266 1269 1272 1275 1278 1281 1284 1287 1290 1293 1296 1299 1302 1305 1308 1311 1314 1317 1320 1323 1326 1329 1332 1335 1338 1341 1344 1347 1350 1353 1356 1359 1362 1365 1368 1371 1374 1377 1380 1383 1386 1389 1392 1395 1398 1401 1404 1407 1410 1413 1416 1419 1422 1425 1428 1431 1434 1437 1440 1443 1446 1449 1452 1455 1458 1461 1464 1467 1470 1473 1476 1479 1482 1485 1488 1491 1494 1497 1500 1503 1506 1509 1512 1515 1518 1521 1524 1527 1530 1533 1536 1539 1542 1545 1548 1551 1554 1557 1560 1563 1566 1569 1572 1575 1578 1581 1584 1587 1590 1593 1596 1599 1602 1605 1608 1611 1614 1617 1620 1623 1626 1629 1632 1635 1638 1641 1644 1647 1650 1653 1656 1659 1662 1665 1668 1671 1674 1677 1680 1683 1686 1689 1692 1695 1698 1701 1704 1707 1710 1713 1716 1719 1722 1725 1728 1731 1734 1737 1740 1743 1746 1749 1752 1755 1758 1761 1764 1767 1770 1773 1776 1779 1782 1785 1788 1791 1794 1797 1800 1803 1806 1809 1812 1815 1818 1821 1824 1827 1830 1833 1836 1839 1842 1845 1848 1851 1854 1857 1860 1863 1866 1869 1872 1875 1878 1881 1884 1887 1890 1893 1896 1899 1902 1905 1908 1911 1914 1917 1920 1923 1926 1929 1932 1935 1938 1941 1944 1947 1950 1953 1956 1959 1962 1965 1968 1971 1974 1977 1980 1983 1986 1989 1992 1995 1998 2001 2004 2007 2010 2013 2016 2019 2022 2025 2028 2031 2034 2037 2040 2043 2046 2049 2052 2055 2058 2061 2064 2067 2070 2073 2076 2079 2082 2085 2088 2091 2094 2097 2100 2103 2106 2109 2112 2115 2118 2121 2124 2127 2130 2133 2136 2139 2142 2145 2148 2151 2154 2157 2160 2163 2166 2169 2172 2175 2178 2181 2184 2187 2190 2193 2196 2199 2202 2205 2208 2211 2214 2217 2220 2223 2226 2229 2232 2235 2238 2241 2244 2247 2250 2253 2256 2259 2262 2265 2268 2271 2274 2277 2280 2283 2286 2289 2292 2295 2298 2301 2304 2307 2310 2313 2316 2319 2322 2325 2328 2331 2334 2337 2340 2343 2346 2349 2352 2355 2358 2361 2364 2367 2370 2373 2376 2379 2382 2385 2388 2391 2394 2397 2400 2403 2406 2409 2412 2415 2418 2421 2424 2427 2430 2433 2436 2439 2442 2445 2448 2451 2454 2457 2460 2463 2466 2469 2472 2475 2478 2481 2484 2487 2490 2493 2496 2499 2502 2505 2508 2511 2514 2517 2520 2523 2526 2529 2532 2535 2538 2541 2544 2547 2550 2553 2556 2559 2562 2565 2568 2571 2574 2577 2580 2583 2586 2589 2592 2595 2598 2601 2604 2607 2610 2613 2616 2619 2622 2625 2628 2631 2634 2637 2640 2643 2646 2649 2652 2655 2658 2661 2664 2667 2670 2673 2676 2679 2682 2685 268

0

THE UNIVERSITY OF CHICAGO

00-21906

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86-28228

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                     |   |  |
|---|--|---|---|---|---------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LOETTA HAYWOOD         |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 17 86 |   | 2b. HOUR<br>8:30p M |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07-10-1897  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW BEDFORD MASS |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD |  |
| 10. CITY OR TOWN OF DEATH<br>City                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |

|  |  |             |  |  |  |   |  |   |  |
|--|--|-------------|--|--|--|---|--|---|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND |  | 13b. COUNTY |  | 13c. CITY OR TOWN<br>BALTIMORE                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>127 W. FAYETTE STREET |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN |  |   |  |   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>26-10-2697 |  | 17. INFORMANT<br>ADDRESS<br>DANIEL HAYWOOD III 2824 RIGGS AVE. |  |
|--|--|---|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST.<br>(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>RENAL FAILURE<br>(c) DIABETES MELLITUS |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>191 86 1917 86  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 10/17 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Kuang-yen Hwang MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/18/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kuang-yen Hwang  |  |  |  | 22e. ADDRESS<br>BON SECOURS Hospital   |  |   |  |

|   |  |                       |  |   |  |  |  |
|---|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                          |  | 23b. DATE<br>10-22-86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. AUBURN Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>BROWN/THOMPSON F.H. 113 W. BALTIMORE ST |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1986          |  | 25b. REGISTRAR'S SIGNATURE                                       |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial permit. Then please remove the Burial permit page and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

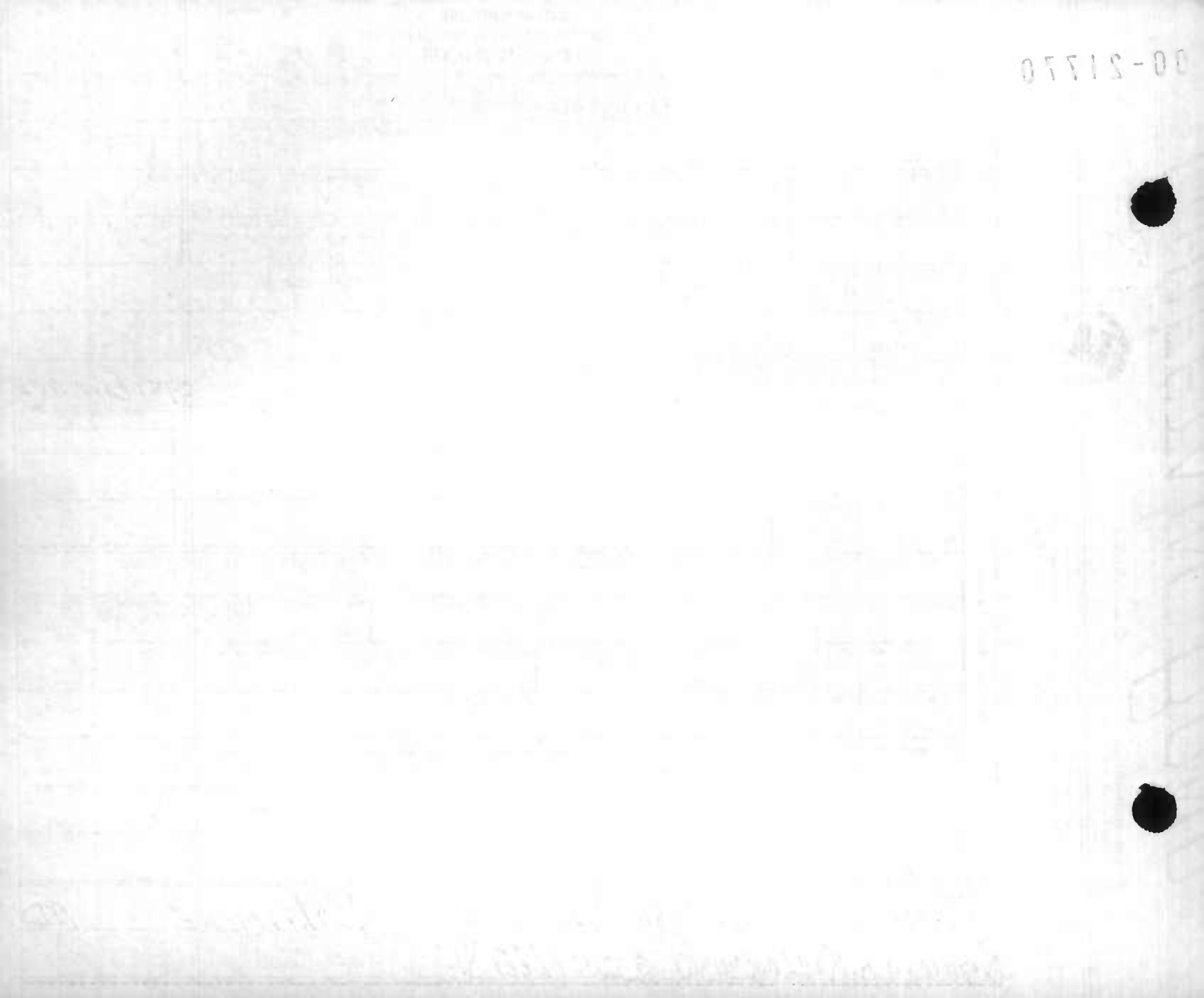
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the death certificate is filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for an autopsy.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |  |
|--|--|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 0 2 8 2 2 7<br>REG. NO.  |   |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JENNIE HEALY   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCT 18, 1986   |   |  | 2b. HOUR<br>1:20 AM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept 21 1931  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.                                    |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.  |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                   |  |  |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen Hosp |   |  |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife     |  | 15. KIND OF BUSINESS OR INDUSTRY   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE Maryland 16b. COUNTY 16c. CITY OR TOWN Baltimore   |  |  |   |  | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 18. STREET ADDRESS / ZIP CODE 2931 Fair Avenue 21224   |  |  |
| 19. FATHER'S NAME FIRST MIDDLE LAST<br>Michael Blama   |  |  |   |  | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Antoinette Motyka  |   |  |  |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |  |   |  | 22. SOCIAL SECURITY NO.<br>216-28-2403   |   | 23. INFORMANT ADDRESS<br>Franklin Healy 2931 Fair Ave  |  |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary Insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) metastatic Adeno Carcinoma of lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |   |  |  |   |  |  |  |
| 25. DATE OF OPERATION  |  |  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  | 27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 32. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 33. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 34. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |
| 35. I certify that (I) (this hospital) attended the deceased from 10/13/86, 1986, to 10/18/86, 1986, that (I) (we) lost saw the deceased alive on 10/18/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |   |  |  |   |  |  |  |
| 36. SIGNATURE<br>Harold Blumenthal MD  |  |  |   |  | 37. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 38. DATE SIGNED<br>Oct 18, 1986  |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold Blumenthal MD   |  |  |   |  | 40. ADDRESS<br>3001 S. Hanover St Baltimore Md   |   |  |  |  |
| 41. BURIAL, CREMATION, REMOVAL (BY)<br>BURIAL  |  |  | 42. DATE<br>10/21/1986  |  | 43. NAME OF CEMETERY OR CREMATORY<br>CARLAWN   |   | 44. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MD |  |  |
| 45. FUNERAL DIRECTOR NAME<br>RAYMOND L. KACZOROWSKI  |  |  |   |  | 46. ADDRESS<br>2525 FLEET ST.  |   | 47. DATE REC'D. BY REGISTRAR<br>OCT 21 1986            |  |  |
| 48. REGISTRAR'S SIGNATURE  |  |  |   |  | 49. REGISTRAR'S SIGNATURE  |   |  |  |  |

00-51350



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-21629

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 2 3 0  
REG. NO.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST CATHERINE LAST HEDEMAN<br>MURIEL C.  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 19 86<br>7b. HOUR<br>9:05 P.M.                        |  |  |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 13 02   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84<br>7c. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, MARYLAND MD.                                 |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KESWICK NURSING HOME |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Towson  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernest F. Sharff  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Snowden   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>214-20-8170A   |   | 17. INFORMANT<br>ADDRESS<br>M.C. Hedeman 1131B Donnington Circle 21204               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>gangrene of 2 toes</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>diffuse arterial atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>diffuse arterial atherosclerosis</u> |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 hours<br>8 weeks<br>10 years   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>---</u>   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) [this hospital] attended the deceased from <u>May 20</u> , 19 <u>81</u> , to <u>Oct 19</u> , 19 <u>86</u> , that (I) <u>was</u> last saw the deceased alive on <u>Oct 19</u> , 19 <u>86</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.  |   |  |   |  |  |
| 22b. SIGNATURE<br><u>W.B. Daniels, Jr.</u>  |   | DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>10/19/86</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. B. Daniels  |   | 22e. ADDRESS<br>700 West Fortieth Street 21211   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>10-22-86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home   |   | ADDRESS<br>6500 York Road 21212  |   | 25. DATE FILED BY REGISTRAR<br><u>OCT 21 1986</u>                                    |  |
|   |   | 25b. REGISTRAR'S SIGNATURE   |   |  |  |

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00-22114

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy of Part I and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  | 8 6   |  | 2 8 2 3 1   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOSEPH HEILIG</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 21 86</b>  |  | 2b. HOUR<br><b>2 30 PM</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>09 12 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>74 YRS</b>                      |  | IF UNDER 1 YEAR<br>IF UNDER 74 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Liberty Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disabled</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>Md</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>525 Lynhurst Ave 21229</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Odell Heilig</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emiley</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-7285</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary Jones 525 Lynhurst St</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>POSSIBLE ASPIRATION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRO-VASCULAR ACCIDENT</b> |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Glaucoma, DIABETES MELLITUS, URINARY TRACT INFECTION</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-10-1986</b> to <b>10-21-1986</b> , that (I) (we) lost <b>10-21-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Sudhir D. Patel</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>10-21-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUDHIR D. PATEL</b>  |  |   |  | 22e. ADDRESS<br><b>LIBERTY MEDICAL CENTER - BALTIMORE</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/25/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY<br><b>Randallstown Md</b>                                  |  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>March Funeral Home West 4300 Wabash Avenue</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |

BP

20% COTTON FIBER

NEW YORK



00-55114



00-20148

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 2 3 2  
REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Catherine F Henderson   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 1 86                                |   | 2b. HOUR<br>8:31 AM                       |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 08 10   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Hennrichs Gen. Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic   |   |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Martin Hartline  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherin Viehmeyer           |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |   | 16b. SOCIAL SECURITY NO.<br>217-22-6845   |   | 17. INFORMANT<br>ADDRESS<br>Mildred Keefe 4108 Sixth St. Balto.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cranial Septic, pneumonia.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>UTI, s/p CVA</u> |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>86</u> , to <u>10/1/86</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |   |
| 22b. SIGNATURE<br>Michael D. M.D.  |   | DEGREE  |   | 22c. DATE SIGNED<br>10/1/86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael OH, M.D.  |   | 22e. ADDRESS<br>3001 S. Harrow St. Baltimore, MD 21230  |   | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>10/4/1986  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Mausoleum Balto., A.A. Co., Md.  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Homes Balto., Md. 21225  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 06 1986  |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |   |

MEDICAL CERTIFICATION

9  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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0-20680

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28233  
REG. NO.

|   |  |   |   |  |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Mary M. Hennigan  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>10 06 86                        |  |  | 2b HOUR<br>6:38 AM   |  |  |  |
| 3 SEX<br>F  |  | 4 RACE<br>B   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 20 49  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.s.a.   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>State Building  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a STATE<br>Maryland   |  |   |   | 13b COUNTY   |  | 13c CITY OR TOWN<br>Baltimore  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anglo Chisley  |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Bernice Queen  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |   | 17 INFORMANT ADDRESS<br>Arthur Hennigan, Jr. 512 E. 23rd St.   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Electromechanical Dissociation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Adult Respiratory Distress Syndrome</u>   |  |   |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>540 P.M. 10 6 86    |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>9-18</u> , 19 <u>86</u> , to <u>10-6</u> , 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>10-6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |  |  |
| 22b SIGNATURE<br>Robert Hino  |  |   |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br>Oct. 6, 1986  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Hino   |  |   |   |  |  | 22e ADDRESS<br>Union Memorial Hospital   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b DATE<br>10-13-86  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cemetery |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |  |
| 24 FUNERAL DIRECTOR<br>MARCH FUNERAL HOMES  |  |   |   |  |  | 25a DATE REC'D. BY REGISTRAR<br>OCT 10 1986  |  | 25b REGISTRAR'S SIGNATURE<br>[Signature]   |  |

MEDICAL CERTIFICATION

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this certificate from the papers, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

BP

WAVE CO. J. J. J. J. J.

WAVE CO. J. J. J. J. J.



00-19990

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 2 3 4  
REG. NO.

|   |  |  |   |  |   |  |
|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALICE M. HENRY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>WED. OCT. 1, 1986</b>         |  | 2b. HOUR<br><b>10 A M</b>   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>BLACK</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 8 1901</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3915 CALLOWAY AVENUE</b> |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>   |  | 13a STREET ADDRESS / ZIP CODE<br><b>3915 CALLOWAY AVE. 21215</b>   |   |  |   |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY   |   | 13c CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN BROWN</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MATILDA ROBINSON</b> |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b SOCIAL SECURITY NO<br><b>212 14 9834</b>   |   | 17 INFORMANT ADDRESS<br><b>MR. WILLIAM HENRY 3818 FERNHILL AVENUE</b>  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ischemic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b>   |
| MEDICAL CERTIFICATION   |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>9/30/86</b> to <b>10/1/86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) I observed the body after death   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>HAROLD M. WALEN MD</b>   |  |  |   | 22c. DATE SIGNED<br><b>10/3/86</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  |   | 23b. DATE<br><b>10/6/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CREST LAWN CEMETERY</b>   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>  |  |  |   | 24b. ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 06 1986</b>  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Walter H. Jones</b>   |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and submitted in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the funeral director. Pages 5 and 6 should be retained by the funeral director. Pages 7 and 8 should be retained by the funeral director. Pages 9 and 10 should be retained by the funeral director. Pages 11 and 12 should be retained by the funeral director. Pages 13 and 14 should be retained by the funeral director. Pages 15 and 16 should be retained by the funeral director. Pages 17 and 18 should be retained by the funeral director. Pages 19 and 20 should be retained by the funeral director. Pages 21 and 22 should be retained by the funeral director. Pages 23 and 24 should be retained by the funeral director. Pages 25 and 26 should be retained by the funeral director. Pages 27 and 28 should be retained by the funeral director. Pages 29 and 30 should be retained by the funeral director. Pages 31 and 32 should be retained by the funeral director. Pages 33 and 34 should be retained by the funeral director. Pages 35 and 36 should be retained by the funeral director. Pages 37 and 38 should be retained by the funeral director. Pages 39 and 40 should be retained by the funeral director. Pages 41 and 42 should be retained by the funeral director. Pages 43 and 44 should be retained by the funeral director. Pages 45 and 46 should be retained by the funeral director. Pages 47 and 48 should be retained by the funeral director. Pages 49 and 50 should be retained by the funeral director. Pages 51 and 52 should be retained by the funeral director. Pages 53 and 54 should be retained by the funeral director. Pages 55 and 56 should be retained by the funeral director. Pages 57 and 58 should be retained by the funeral director. Pages 59 and 60 should be retained by the funeral director. Pages 61 and 62 should be retained by the funeral director. Pages 63 and 64 should be retained by the funeral director. Pages 65 and 66 should be retained by the funeral director. Pages 67 and 68 should be retained by the funeral director. Pages 69 and 70 should be retained by the funeral director. Pages 71 and 72 should be retained by the funeral director. Pages 73 and 74 should be retained by the funeral director. Pages 75 and 76 should be retained by the funeral director. Pages 77 and 78 should be retained by the funeral director. Pages 79 and 80 should be retained by the funeral director. Pages 81 and 82 should be retained by the funeral director. Pages 83 and 84 should be retained by the funeral director. Pages 85 and 86 should be retained by the funeral director. Pages 87 and 88 should be retained by the funeral director. Pages 89 and 90 should be retained by the funeral director. Pages 91 and 92 should be retained by the funeral director. Pages 93 and 94 should be retained by the funeral director. Pages 95 and 96 should be retained by the funeral director. Pages 97 and 98 should be retained by the funeral director. Pages 99 and 100 should be retained by the funeral director.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |  |   |  |  |
|--|--|--|---|---|---|--|---|--|--|
| 1- FOR STATE REGISTRAR   |  | 86   |   | 28  |   | 23   |   | 5  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Baby Ashley Lynn Hepler  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10-28-86  |   |  |   | 7b. HOUR<br>9:10 AM  |  |
| 1. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASIAN   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 25 86   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>— YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 2b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Unit of MD |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE                |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>NONE  |  |
| 13a. STATE<br>Maryland   |  |  |   | 13b. COUNTY<br>Anne Arundel   |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>7826 Outing Ave 21122  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eugene Sue Hepler   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO              |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>NONE   |  |  |   | 17. INFORMANT ADDRESS<br>James Earl Leopard 7826 Outing Ave 21122   |   |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>extreme promonty</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>44 hrs |  |  |   |   |   |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/28, 19 86, to 10/28, 19 86, that (1) (we) last saw the deceased alive on 10/28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.   |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br>Michael Brown MD   |  |  | DEGREE  |   |   | 22c. DATE SIGNED<br>10/28/86   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Brown MD  |  |  | 22e. ADDRESS<br>22 S. Green St Balt MD 21201                        |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>10-31-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cemetery |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph N. Zannino Jr.  |  |  | ADDRESS<br>263 S. Conkling St.                                      |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 30 1986              |  |   |  |  |

101-2-2-31  
[Faint handwritten text, mostly illegible]

CHIEF

2080 CHIEF



00-22456

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28236  
REG. NO.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA E. HERCZEG</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 24 1986</b> |   |  | 2b. HOUR<br><b>3:29 P.M.</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 - 15 - 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b>  |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>616 N. BOULDER ST. 21205</b> |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES KRANIECZ</b>                  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANN BOLECZ</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>171-05-4671</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>EMERY HERCZEG, JR 616 N. BOULDER ST. 21205</b>   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**BRAINSTEM INFARCT WITH RESPIRATORY ARREST.**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ACUTE CEREBROVASCULAR OCCLUSION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **HYPERTENSIVE CARDIOVASCULAR DISEASE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**ADVANCED RENAL INSUFFICIENCY**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 19 79</b> to <b>OCTOBER 24 19 86</b> that (I) (we) last saw the deceased alive on <b>OCTOBER 24 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Joseph D. Notarangelo M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10-24-1986</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH D. NOTARANGELO M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>301 ST. PAUL PLACE - BALTIMORE 21202</b>  |  |   |  |

|   |  |                              |  |  |  |  |  |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>10-29-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY SAVIOUR CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BETHLEHEM PA.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HARTLEY MILLER</b>         |  |                              |  | ADDRESS<br><b>7527 HARFORD RD. BALTIMORE MD.</b>               |  | 25a. DATE REC'D. BY REGISTRATION<br><b>0011291986</b>              |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in the burial transit permit. Then please remove carbon papers, pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-55-00



00-22475

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that if death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |             |   |                                |  |   |  |  |  |
|---|--|---|-------------|---|--------------------------------|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |             |   |                                |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH S. HERMANSON  |  |   |             |   |                                | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 22, 1986                                       |   | 2b. HOUR<br>6:15P M  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |             | 5. DATE OF BIRTH MONTH DAY YEAR<br>SEPT. 28, 1906   |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                 |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7207 VALLEY COUNTRY CT., APT. T-1 |             |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>GROCER                    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>FOOD  |  |  |
| 13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY |   | 13c. CITY OR TOWN<br>BALTIMORE |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7207 VALLEY COUNTRY CT. #21208 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MAX SILVERMAN  |  |   |             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>RACHEL SCHWARTZBERG   |                                |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |   |             | 16b. SOCIAL SECURITY NO.<br>216-01-0930   |                                | 17. INFORMANT ADDRESS<br>MRS. SUZANNE H. HORWITZ<br>8333 SCOTTS LEVEL RD. BALTO., MD 21208 |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-Vascular</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>—</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a |  |   |             |   |                                |  |   |  |  |  |
| MEDICAL CERTIFICATION   |  |   |             |   |                                |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |             |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                                |  |   |  |  |  |
| 22a. I certify that (I, the hospital) attended the deceased from <u>Sept 4</u> , 19 <u>45</u> , to <u>Oct 22</u> , 19 <u>86</u> , that (I) <u>was</u> last saw the deceased alive on <u>7-10</u> , 19 <u>86</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (If not, I did not view the body after death.)  |  |   |             |   |                                |  |   |  |  |  |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE <u>—</u>   |  |   |             |   |                                | 22c. DATE SIGNED<br>10/23/86   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL N TOMPAKOV, M.D.  |  |   |             |   |                                | 22e. ADDRESS<br>7211 PARK HTS. AVE. BALTO., MD 21208                                       |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>OCT. 24, 1986  |             | 23c. NAME OF CEMETERY OR CREMATORY<br>SHAAREI TFILOH  |                                | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                              |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |             |   |                                | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1986   |   | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |  |

BP

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*[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page. Some words like "25", "24", "23" are visible.]*

00-22983

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28238

1- FOR  
STATE  
REGISTRAR

|  |                         |  |   |   |  |
|--|-------------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph John Herold, Jr.</b>   |                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC <b>10/31/19 86</b> |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Cauc.</b> | 5. DATE OF BIRTH<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>9/15/63</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>23 YRS.</b>   | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/> SEC <input type="checkbox"/>                  | 7c. DATE PRONOUNCED DEAD<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>10/ 31/19 86</b> |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>Baltimore City, Md.</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital Shock Trauma</b>  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Construction</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |                         |  |   |   |  |
| 13a. STATE<br><b>Md.</b>   |                         |  |   |   |  |
| 13b. COUNTY<br><b>--</b>   |                         | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>4329 Robertson Ave. 21206</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph John Herold, Sr.</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia M. Anderson</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>214-96-5339</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>same as above</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>8122</b> IMMEDIATE CAUSE (a) <b>Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>19a. DATE OF OPERATION</b> <b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b> <b>20. AUTOPSY?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                         |  |   |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>12:17AM 10/31/19 86</b>   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>operator of motorcycle/auto collision</b>  |   |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>roadway</b>  |                         | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/><br><b>Belair Rd. &amp; Seidel Ave., Balto. City, Md.</b> |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>  |   | DATE SIGNED<br><b>10/31/86</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn St.</b>  |                         |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>11/3/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore, Md.</b>   |                         | COUNTY<br><b>Baltimore</b>   |   | STATE<br><b>Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SCHIMUNEK FUNERAL HOME, Balto, Md. 21213</b>  |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>5 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Anderson-Kendall</b>   |  |

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

90% COTTON LIME

CHRYSTAL BRAND



00-5555-00



00-21974

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 2 3 9  
REG. NO.

|  |  |  |  |   |  |   |   |  |  |  |
|--|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RUTH HERTZBACH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 16, 1986</b>   |   |  | 2b. HOUR<br><b>10:12<sup>A</sup></b>  |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 6, 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                     |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br><b>JACOB</b> MIDDLE <b>BARNISH<sup>ST</sup></b>   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>DORA</b> MIDDLE <b>KERNER</b> LAST  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                        |   |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-0753</b> |  |
| 17. INFORMANT<br><b>JEROME HERTZBACH</b> ADDRESS<br><b>2508 SUMMERSON RD. BALTO., MD 21209</b>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>OVERWHELMING SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPOTENSION, MITRAL VALVE DISEASE, SEIZURES POSSIBLE PYELONEPHRITIS, HEPATIC FAILURE, RENAL FAILURE</b> |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 MINUTES</b><br><b>7 DAYS</b><br><b>3 MONTHS</b> |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>10/12/86</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>SEPSIS, GALLSTONES, TUBC PULMONARY</b>  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> , 19 <b>86</b> , to <b>10/16</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/16</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>R. S. Finney MD</b>   |  |  | DEGREE   |   |  | 22c. DATE SIGNED<br><b>10/16/86</b>   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. S. FINNEY</b>   |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL BALTIMORE, MD</b>  |   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>OCT. 17, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SWINICHER WOLINER BENEV. ASSOC.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |   |  |   |   |  |  |  |

MEDICAL CERTIFICATION

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BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires no further action by the physician. It should be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. The detached portion should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-51238

EX-55 FOR  
JAN 55 1955  
U.S. DEPT. OF JUSTICE

RECEIVED  
JAN 55 1955  
U.S. DEPT. OF JUSTICE

00-21458

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 2 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

|  |  |  |  |   |   |   |  |  |  |  |  |
|--|--|--|--|---|---|---|--|--|--|--|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  | REG. NO. 86 28240                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Charles J. Hessian   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/14/86 |   |  | 2b. HOUR<br>11 P.M.  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 13 08   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>0 0  |  | 8. UNDER 1 YEAR<br>HOURS MIN.<br>0 0         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore city  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>N. Charles General Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attorney        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Law   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |  |  | 13b. COUNTY<br>Balto.   |   | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Hessian  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Martin  |   |   |  | 13e. STREET ADDRESS / ZIP CODE<br>216 W. Madison St., 21201  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II   |  | 17. INFORMANT<br>220 22 4717  |   | Mrs. Alice W. Hessian,  |  | Same   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration and pulmonary edema</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left Kidney pyelonephritis, abscess</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe cystitis, hematuria</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><u>Jackson's Disease, Depression, Renal insufficiency</u>  |  |  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)   |   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/8/86</u> to <u>10/14/86</u> , that (I) (we) last saw the deceased alive on <u>10/14/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Marcos B. Galicia</u>   |  |  |  | DEGREE<br>MD  |   |   |  | 22c. DATE SIGNED<br>10/14/86   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARCOB B. GALICIA, MD   |  |  |  | 22e. ADDRESS<br>North Charles GEN. Hospital   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>10/16/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD                            |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1986  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

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00-22433

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 2 4 1  
REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Leroy M. Hetrick   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 26 86                             |   | 2b. HOUR<br>8:00<br>P M   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 30 19  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67<br>YRS.                               |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>--   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herbert F. Hetrick  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Miller   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II 212-18-8060  |   | 17. INFORMANT<br>ADDRESS<br>Edith Lockner 3318 Elm Avenue 21211               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Blow Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Years</u><br>Approximate interval between onset and death<br><u>Minutes</u>                  |  |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u>  |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3-26</u> 19 <u>89</u> to <u>10/26</u> 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>10/26 9/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |   |   |   |
| 22b. SIGNATURE<br><u>Richard L. Diamond</u>   |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>10-27-86  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard L. Diamond M.D.  |  | 22e. ADDRESS<br>3547 Chestnut Ave Balt. Md 21211  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>10/30/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland              |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr. 3818 Roland Ave. 21211   |  | 25. DATE REC'D. BY REGISTRAR<br>10/28/86  |   | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                               |   |

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

00-33132

00-33132

Page 1

00-22739

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28242  
REG. NO.

|   |  |  |   |   |   |   |   |   |  |
|---|--|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lillian Hettleman  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 / 29 / 86       |   |   | 2b. HOUR<br>1534 M  |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 / 28 / 01  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital - Balt. Md 21215 |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MD. |  |  | 13c. CITY OR TOWN<br>Baltimore                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>7 Slide Ave 21208 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Cohen  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frieda ? |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                  |  | 16b. SOCIAL SECURITY NO.<br>217-26-5204  |   | 17. INFORMANT<br>ADDRESS<br>Michael Hettleman 7 Schloss Gt. 21208   |   |   |   |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Resp. Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>As of Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Severe Fibrotic Lung Disease</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

## MEDICAL CERTIFICATION

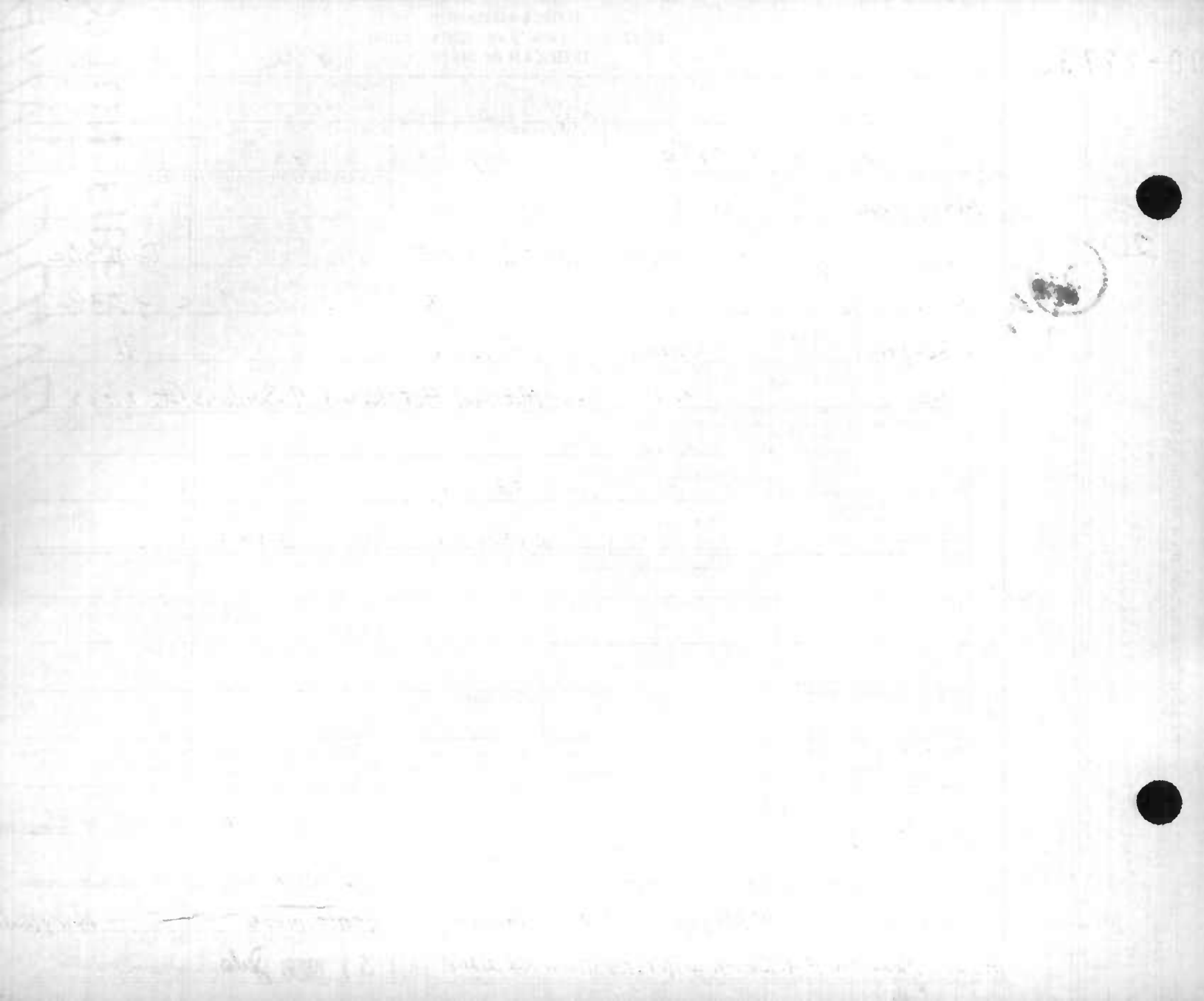
|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Craig Curry   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/29/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Craig Curry  |  |  |  | 22e. ADDRESS<br>Sinai Hospital   |  |   |  |

|  |  |                       |  |  |  |  |  |
|--|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                 |  | 23b. DATE<br>10/30/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Chizuk Amuno |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hebrew Memorial F.H. Inc. - 1100 Reisterstown Rd 21208 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1986       |  | 25b. REGISTRAR'S SIGNATURE<br>John [Signature]                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon copy and file it in the office of the funeral director. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 6 2 8 2 4 3<br>REG. NO.   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST LUCY MIDDLE ADELE LAST HEUSLER<br><i>Lucy A. Heusler</i>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 7 86   |  | 2b. HOUR<br>11:5 M  |  |  |  |  |  |
| 3. SEX<br>Female<br><i>Female</i>   |  | 4. RACE<br>White<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>February 12, 1890  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS  |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>md. Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Den Mother   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Private   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE<br>401 N. Loudon Ave. 21229   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Unknown  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>214-18-9417   |  | 17. INFORMANT ADDRESS<br>E.M. Sullivan 104 Springside Dr. 21093   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>extensive decubitus ulcers</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>senile dementia</i>   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>26/9/29</i> , 19 <i>86</i> , to <i>10/7</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>10/7</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Honayoon Moagabdi M.D.</i>   |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><i>10/7/86</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Honayoon Moagabdi</i>   |  | 22e. ADDRESS<br><i>BON SECOURS HOSPITAL</i>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10-9-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home   |  | ADDRESS<br>6500 York Road 21212   |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>OCT 14 1986</i>   |  |  |  |  |  |

[Faint, mostly illegible text covering the majority of the page, likely a memorandum or report.]



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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 8 2 4 4

|  |                         |   |   |  |   |  |   |  |
|--|-------------------------|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT HEWITT, JR.</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10/ 30/ 86</b> |  |   | 2b. HOUR<br>M <b>8:44</b><br>P <b>M</b>                                      |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Aug. 30 1986</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>2</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>10/ 30/ 86</b>                 |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Medical Center</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>Md.</b>   |                         |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Dundalk</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>8122 Stratman Rd. 21222</b>                        |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Hewitt Sr.</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Linda Grear</b>                                       |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT ADDRESS<br><b>Robert Hewitt Sr. 8122 Stratman Rd.</b>                             |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |                         |   | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>  |  |   |  | DATE SIGNED <b>10/31/86</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |                         |   | ADDRESS <b>111 Penn St.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |                         |   | 23b. DATE<br><b>11/3/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardensof Faith</b>                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rossville Balto. Maryland</b>      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ConnellyFuneralHome 300MaceAve. 21221</b>   |                         |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV - 6 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Sanders-Randall</i>                          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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NOT FOR COLLECTION

NOV 19 1964



00-20821

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the funeral director. Page 4 should be filed with the funeral director after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the medical examiner.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |  |   |   |  |
|--|--|--|---|---|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR 10/16/86 by F.H.  |  |  |   |   |  |  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Diamond L. Hickey  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10-11-86                                   |  |  |   |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>12-10-2-07   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  | 2b. HOUR<br>8:27  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Wisc.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD                                 |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman - Ret.     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction   |   |  |
| 13a. STATE<br>MD   |  |  |   |   | 13b. COUNTY<br>Anne Arundel  |  | 13c. CITY OR TOWN<br>Glen Burnie                                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas Diamond  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Alice Limbon                          |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |   |   | 16b. SOCIAL SECURITY NO.<br>394 070287   |  | 17. INFORMANT ADDRESS<br>Glen Hickey, son, 706 Wesley Rd., Glen Burnie |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of R Lung<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |   |   |  |  |  |   |   |  |
| MEDICAL CERTIFICATION  |  |  |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-9 19 86, to 10-11 19 86, that (I) (we) last saw the deceased alive on 10-11 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |   |   |  |
| 22b. SIGNATURE<br>D. Buck, M.D.  |  |  |   |   | DEGREE<br>M.D.   |  |  | 22c. DATE SIGNED<br>10-11-86  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. Buck, M.D.   |  |  |   |   | 22e. ADDRESS<br>3001 South Hanover St., Baltimore, MD 21230                    |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>13 Oct. 86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Catonsville, Balto., Md.    |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>James S. Kirkley, Glen Burnie, Md.  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986                                   |  | 25b. REGISTRAR'S SIGNATURE   |   |   |  |

1. The first part of the report is a description of the work done during the period from January 1, 1950, to December 31, 1950.

2. The second part of the report is a description of the work done during the period from January 1, 1951, to December 31, 1951.

3. The third part of the report is a description of the work done during the period from January 1, 1952, to December 31, 1952.

4. The fourth part of the report is a description of the work done during the period from January 1, 1953, to December 31, 1953.

5. The fifth part of the report is a description of the work done during the period from January 1, 1954, to December 31, 1954.

6. The sixth part of the report is a description of the work done during the period from January 1, 1955, to December 31, 1955.

7. The seventh part of the report is a description of the work done during the period from January 1, 1956, to December 31, 1956.

8. The eighth part of the report is a description of the work done during the period from January 1, 1957, to December 31, 1957.

9. The ninth part of the report is a description of the work done during the period from January 1, 1958, to December 31, 1958.

10. The tenth part of the report is a description of the work done during the period from January 1, 1959, to December 31, 1959.

11. The eleventh part of the report is a description of the work done during the period from January 1, 1960, to December 31, 1960.

12. The twelfth part of the report is a description of the work done during the period from January 1, 1961, to December 31, 1961.

13. The thirteenth part of the report is a description of the work done during the period from January 1, 1962, to December 31, 1962.

00-20822

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner should be notified.

## MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| Tt.ms, #5,13a, G-620, 10/10<br>FOR<br>1- STATE by F.H. / Gbj.<br>REGISTRAR<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH<br>86 NO. 28246   |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THELMA L Hickey</b>  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 11 86</b>  |  | 2b. HOUR<br>9 <sup>00</sup> P <sup>M</sup>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>Aug 27, 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 4 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Mich.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>AA</b>   |  | 13c. CITY OR TOWN<br><b>GLEN BURNIE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>706 WESLEY RD. 21061</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Lewis</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Ann Lewis</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>187-44-1389</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Glen Hickey, son, 706 Wesley Rd., Glen Burnie</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>KIDNEY Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Unknown</b>                                    |  |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>09-25-86</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GANGLIONE of Small Bowel</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>09/24/86</b> to <b>10/11/86</b> , that (we) lost saw the deceased alive on <b>10/11/86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Kwang N. Kim M.D.</b>  |  |  |  |  |  | 22c. DATE SIGNED<br><b>10-11-86</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KWANG N. KIM M.D.</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>3801 S. FRANKLIN ST. 21230</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Oct. 13, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Balto., Md.</b>                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>James S. Kirkley, Glen Burnie, Md.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Seaton</b>   |  |

STREET

COLLEGE STREET



00-22779

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH88 28247  
REG. NO.

|  |  |  |   |   |                                 |  |   |  |   |  |  |
|--|--|--|---|---|---------------------------------|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Catherine</u>   |  |  | 2a. DATE OF DEATH<br>MONTH <u>10</u> DAY <u>25</u> YEAR <u>86</u>                 |   |                                 | 2b. HOUR<br><u>12:02 AM</u>  |   |  |   |  |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>Black</u>  |   | 5. DATE OF BIRTH<br>MONTH <u>1</u> DAY <u>28</u> YEAR <u>29</u>   |                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>57</u> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN. <u>  </u>  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Balto.</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Bon Secours Hospital</u> |   |   |                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>unemployed</u>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>MD</u>   |  |  | 13b. COUNTY <u>Balto.</u>   |   | 13c. CITY OR TOWN <u>Balto.</u> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><u>303 N. GILMORE ST. 21223</u> |  |  |
| 14. FATHER'S NAME<br>FIRST <u>Stephen</u> MIDDLE <u>  </u> LAST <u>Hill</u>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Irene</u> MIDDLE <u>  </u> LAST <u>White</u> |   |                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>NO</u>   |   |  |   | 16b. SOCIAL SECURITY NO.<br><u>218 26 6917</u> |  |
| 17. INFORMANT<br><u>DELOIS REED</u>  |  |  | ADDRESS<br><u>2319 WHITTIER AVE 21215</u>   |   |                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>  </u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>  </u>   |  |  |   |   |                                 |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>  </u> P.M. <u>  </u> <u>19</u>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                 |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                 |  |   |  |   |  |  |
| 22a. I certify that <u>  </u> (this hospital) attended the deceased from <u>10-19-1986</u> , to <u>10-25-1986</u> , that <u>  </u> (we) last saw the deceased alive on <u>10-25-1986</u> , and that in <u>  </u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>  </u> (we) (did) (did not) view the body after death. |  |  |   |   |                                 |  |   |  |   |  |  |
| 22b. SIGNATURE<br><u>  </u> M.D.   |  |  |   | 22c. DATE SIGNED  |                                 |  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>AMAEFULE</u>   |   |  |  |
| 22e. ADDRESS<br><u>Bon Secours Hospital</u>  |  |  |   | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>BURIAL</u>  |                                 |  |   |  |   |  |  |
| 23b. DATE<br><u>11-1-86</u>  |  |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ARBUTUS</u>  |                                 |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>ARBUTUS MD</u>  |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>MARCH FUNERAL HOME</u>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 31 1986</u>   |                                 |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>  </u>  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be called on duty.



00-21472

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28248

1- FOR  
STATE  
REGISTRAR

|   |         |  |  |   |  |  |  |   |  |  |  |   |  |
|---|---------|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                                     |  | MONTH DAY YEAR                             |  | 2b. HOUR  |  |
| CORA  |         | LEE  |  | HILL  |  |  |  | X   |  | 10-10-86                                   |  | M   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                            |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.  |  | 2c. DATE<br>PRONOUNCED<br>DEAD             |  | 2d. HOUR  |  |
| FEMALE  | BLACK   | 05-29-10   |  | 76 YRS.   |  |  |  |   |  | 10-10-86                                   |  | 4:30a   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |
| VIRGINIA  |         | USA  |  | WIDOWED   |  | DIVORCED   |  | Baltimore City  |  |  |  | MD  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY       |  |   |  |
| Baltimore   |         | 1613 Longwood Street   |  |   |  | MINISTER   |  |   |  |  |  |   |  |
| 13a. STATE  |         |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                        |  |   |  |
| Maryland  |         |  |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 1613 LONGWOOD ST.                          |  |   |  |
| 14. FATHER'S NAME   |         |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |  |  |   |  |  |  |   |  |
| MORT JACKSON  |         |  |  | ESTELLE SHELTON   |  |  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         |  |  | 16b. SOCIAL SECURITY NO.                                      |  |  |  | 17. INFORMANT ADDRESS   |  |  |  |   |  |
| NO  |         |  |  |   |  |  |  | ESTELLE BLACKWELL 1613 Longwood   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| IMMEDIATE CAUSE (a) Carcinoma of lung   |         |  |  |   |  |  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |  |  |  |   |  |  |  |   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.  |         |  |  |   |  |  |  |   |  |  |  |   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |  |  |  |   |  |  |  |   |  |
| (c)   |         |  |  |   |  |  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |         |  |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |  |  |   |  |  |  | 20. AUTOPSY?  |  |
|   |         |  |  |   |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR               |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |
|   |         |  |  | P.M. 19   |  |  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME<br>STREET, FACTORY, FARM, ETC.) |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |   |  |
|   |         |  |  |   |  |  |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE  |         |  |  | TITLE (SPECIFY)   |  |  |  | DATE SIGNED   |  |  |  |   |  |
| Margarita A. Korell, M.D.   |         |  |  | M.D. Assistant  |  |  |  | MEDICAL EXAMINER  |  |  |  | 10-10-86  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         |  |  | ADDRESS   |  |  |  |   |  |  |  |   |  |
| Margarita A. Korell, M.D.   |         |  |  | 111 Penn Street   |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                               |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |  |
| BURIAL  |         |  |  | 10-18-86  |  | MT. AUBURN Cem.  |  |   |  | BALTIMORE, Maryland                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |         |  |  | ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Brown/Thompson F.H.   |         |  |  | 1913 W. Balto. St   |  |  |  | OCT 17 1986   |  |  |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASONS IN PENCIL IN ITEM 18. RETAIN PAGE 3 FOR YOUR FILES.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 4 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (15))

MEDICAL CERTIFICATION

2012 OCT 18 11:10

2012 OCT 18 11:10

2012 OCT 18 11:10





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

20243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be accepted within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician at the place of death, it should be detached for use as the burial permit. Then please remove carbon papers, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filled out once.

|   |  |   |  |   |   |   |  |  |  |  |  |  |  |                             |  |
|---|--|---|--|---|---|---|--|--|--|--|--|--|--|-----------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  | REG. NO. 8 2 8 2 5 0                         |  |  |  |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Edward Hinson   |  |   |  |   | 2a. DATE OF DEATH<br>10-3-86  |   |  | 2b. HOUR<br>2:59pm   |  |  |  |  |  |                             |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>9-13-14   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |  |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                   |  |  |  |  |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md 13b. COUNTY 13c. CITY OR TOWN Baltimore   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>2004 W. Hexington St 21223 |  |  |  |  |  |  |                             |  |
| 14. FATHER'S NAME<br>James Hinson   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>Bessie Streater   |   |  |  |  |  |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>247-22-8192   |  | 17. INFORMANT ADDRESS<br>Howell Hinson 1712 Ruxton Avenue   |   |   |  |  |  |  |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF (c) Old CVA = Left Hemiparesis<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |                             |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |  |  |  |  |  |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-19-86 to 10-3-86, that (I) (we) last saw the deceased alive on 10-3-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |  |  | 22b. SIGNATURE<br>A.I. Bankaler              |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10-3-86 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.I. BANKALER, MD  |  |   |  |   | 22e. ADDRESS<br>831 Poplar Grove St. Bal.   |   |  |  |  |  |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>10/10/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Auburn Cemetery  |   |  | 23d. LOCATION<br>Baltimore COUNTY MD   |  |  |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue  |  |   |  |   | 25a. DATE REC'D BY REGISTRAR<br>OCT 07 1986   |   | 25b. REGISTRAR'S SIGNATURE                                   |  |  |  |  |  |  |                             |  |

-50513



WATERBURY

WATERBURY

WATERBURY

10-2-10

10-2-10

WATERBURY



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 0 2 8 2 5 1  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Arthur Hobbs  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/13/86   |  | 2b. HOUR<br>9 A M   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Wht.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 8 - 34   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51                                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Smith, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Smith, Md.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1816 W. Lombard St. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Smith  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.<br>714-38-1561   |  | 17. INFORMANT<br>AND Hobbs - 1007 Harpers Ave 3rd St.                       |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>A. S. Rite</u>  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br>10-14-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. S. Rite  |  |  |  | 22e. ADDRESS<br>2118 W. Pratt St Ball 21223   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  | 23b. DATE<br>10/16/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>City or Town County State<br>Smith Md.                     |  | 23e. DATE REC'D. BY REGISTRAR<br>OCT 29 1986   |  |
| 24. FUNERAL DIRECTOR<br>Name Address<br>J. J. J. - 1712 W. North   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1986  |  |   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>J. J. J.   |  |  |  |   |  |   |  |  |  |

Dear Sir,

I have the pleasure to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours faithfully,

W. J. [Signature]

Enclosed for you are the same as before.

00-21720

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8028252  
REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH MONTH DAY YEAR  |   | 2b. HOUR  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Emily Hoeffler</i>   |   | October 19, 1986  |   | 2:45 AM   |  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 26 1911   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br>75   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.    |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br>Maryland  |   | 13c. CITY OR TOWN<br>Prince Geo. Laurel   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            | 13e. STREET ADDRESS / ZIP CODE<br>6317 Sandy St. Laurel 20707 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Andrew Mench  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Jennie Not Known  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   | 16b. SOCIAL SECURITY NO.<br>214-40-9511   | 17. INFORMANT ADDRESS<br>William H. Hoeffler Same as 13e  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabete</u>   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>19</u>   |   |   |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)   | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 4,</u> 19 <u>86</u> , to <u>October 19,</u> 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 19,</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><i>Darab Hormozi</i>   | DEGREE<br>MD  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   | 22c. DATE SIGNED<br>10/19/86                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DARAB HORMOZI   |   | 22e. ADDRESS<br>Maryland General Hospital   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>10-22-86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge   | 23d. LOCATION CITY OR TOWN COUNTY STATE   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck Funeral Home of Dundalk<br>7922 Wise Ave Dundalk, Md. 21222   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 22 1986  |   |   |  |

10510-00



101100-2902



00-22457

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 8 2 5 3  
REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)                                   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
|   |  | Anna B. Hoffman  |  |  |  | 10-27-86  |  | 100 PM                                       |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR MONTHS DAYS               |  |
| F   |  | W  |  | 10-23-1897   |  | 89  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| NEW YORK  |  | U. S. A.   |  |  |  | Baltimore   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore City  |  | The Union Memorial Hospital  |  | BOOKKEEPER   |  | FURNITURE CO.   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE               |  |
| MD.   |  |  |  | BALTO.   |  |   |  | 1336 W. 41st St. 21211                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                         |  |  |  |   |  |  |  |
| PATRICK BARDON  |  | AGNES FITZPATRICK  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |
| No  |  | 213-10-3765  |  | Mrs. Lea A. Kunkle   |  | 2913 OAKCREST AVE.  |  | 21234  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   |  | Congestive heart failure   |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | Cardiomyopathy  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  | 1 mos.                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| Right Femoral Bypass 10/11/86   |  |  |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
|   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/3, 1986, to 10/27, 1986, that (I) (we) lost saw the deceased alive on 10/27, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |
| Valerie S. Barnwell   |  | MD   |  | 10/27/86   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| Valerie S. Barnwell   |  | The Union Memorial Hospital  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |
| BURIAL  |  | 10-30-86   |  | NEW CATHEDRAL  |  | BALTO., MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Hartley Miller  |  | - 7527 Harford Rd.   |  | OCT 29 1986  |  |   |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

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FBI

STANDARD FORM NO. 64

00-22099

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

CLEMENT 8/23/13

REG NO.

2 8 2 5 4

|   |                         |  |  |   |  |
|---|-------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLEMENT WARNER HOLLINGSWORTH</b>  |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Oct 19 1996</b>  |  | 2b. HOUR<br>MIN.<br><b>11:16P</b>   |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 23 13</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>73</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |                         | 10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |  |   |  |
| 11a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE<br><b>MD</b> |                         | 12b. CITY OR TOWN<br><b>PARKVILLE</b>  |  | 12c. STREET ADDRESS / ZIP CODE<br><b>8905 NATHAN WOODS MD. 21234</b>  |  |
| 13. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CLEMENET W. HOLLINGSWORTH SR.</b>  |                         | 14. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE E. LONG</b>  |  |   |  |
| 15a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                      |                         | 15b. SOCIAL SECURITY NO.<br><b>216-05-5599</b>   |  | 16. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>OCT 19</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>B. J. Hart</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Oct. 19, 1986</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARBARA J. CHART</b>  |  | 22e. ADDRESS   |  |  |  |   |  |

|   |  |                                       |  |   |  |  |  |
|---|--|---------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                  |  | 23b. DATE<br><b>10/23/86</b>          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOGELAND MEMORIAL PARK</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALT. MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br><b>EVANS CHAPEL OF MEMORIES</b> |  | ADDRESS<br><b>PARKVILLE MD. 21234</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1986</b>                 |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                         |  |

MEDICAL CERTIFICATION

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified by you.

RECEIVED  
JAN 10 1964

UNITED STATES DEPARTMENT OF JUSTICE

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]



RE: [Illegible]

[Illegible body text]

Very truly yours,  
[Illegible signature]



00-22896

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 2 8 2 5 5  
REG. NO.

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Louis Camillus Holly                |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 29 86 |   |  | 2b. HOUR<br>0920 A.M.  |  |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>B  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 26 07  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  | 6. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Clements, Md.                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mason F. Lord Nursing Home |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>St. Mary's   |   | 13c. CITY OR TOWN<br>Loveville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>General Delivery 20656 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Francis Holly               |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Forrest  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br>Rt. 1 Box 145<br>John Leroy Holly Mechanicsville, Md.   |  |  |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Presumed sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Severe decubitus ulcers<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Dementia |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>3 mos<br>13 years |  |
|--|--|---|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Poor nutrition, microcytic anemia  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>N/A   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (if this hospital attended the deceased from 9/10, 1973, to 10/29, 1986, that (I) we last saw the deceased alive on 10/29, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not know the body after death) |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Melvin Hectar   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/29/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Melvin Hectar  |  |  |  | 22e. ADDRESS<br>Francis Scott Key Medical Center, Baltimore  |  |  |  |

|  |  |                      |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                        |  | 23b. DATE<br>11/3/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Queen of Peace |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Helen St. Mary's Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME W. Clarke Mattingley ADDRESS Leonardtown, Md. |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1986          |  | 25b. REGISTRAR'S SIGNATURE<br>Julia F. Smith                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove certificate from this form and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-20186

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28256  
REG. NO.

|   |  |   |   |  |   |  |
|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anna Margaret Holmes</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-5-1986</b>                   |  | 2b. HOUR<br><b>1:53 P.M.</b>                    |  |
| 3 SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-17-1902</b>                              |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5405 Greenhill Ave. 21206</b>  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hugh P. Bannon</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine O'Neill</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>Bernardine Thomas, Same as 13e</b>                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diffuse Multiple Cardiac Necrosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b>   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Diabetes Mellitus</b>  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>September 10, 1986</b> to <b>August 15, 1986</b> , that (I) (we) last saw the deceased alive on <b>August 15, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Alejandro Mejia</b>  |  |   |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alejandro Mejia, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>405 Frederick Rd. Catonsville, Md 21228</b>                       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10-9-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                           |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>  |  |   |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc., 5305 Hartford Rd.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 07 1986</b>                                  |   |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE   |   |  |

MEDICAL CERTIFICATION

The medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00-20100



23275 NOV-78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28257

FOR  
1- STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

HENRIETTA

L.

HOLSEY

2. SEX

female

4. RACE

black

3. DATE OF BIRTH

5 17 1911

6. AGE (IN YEARS)

75 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2b. DATE KNOWN  
OF ESTI-  
MATED

10-31-86

2b. HOUR

2:26P

2c. DATE  
PRONOUNCED  
DEAD

10-31-86

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Va

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

3816 Derby Manor Rd.

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3816 Darby Manor Drive 21215

14. FATHER'S NAME

Steven

MIDDLE

Layton

15. MOTHER'S MAIDEN NAME

Hattie

MIDDLE

Kelley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

217-20-9267

17. INFORMANT

ADDRESS

Jean Butler 1413 N. Ellwood Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

XXXXXXXXXXXXXXXXXXXX

(b) carcinoma of breast

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☐Inquiry ☒

and in my opinion

death resulted from:

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL

SIGNATURE

Margarita A. Korell

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE

SIGNED 11-3-86

EXAMINER'S NAME  
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

11/6/86

23c. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

23d. LOCATION  
CITY OR TOWN

Arbutus

COUNTY

STATE

Md

24. FUNERAL DIRECTOR

NAME

ADDRESS

March Funeral Home West 4300 Wabash Avenue

25a. DATE REC'D. BY REGISTRAR

NOV - 5 1986

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))

33517 10-4-71

REGIT KOTOO 500E

WIND  
WAVE  
D



00-20515

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28258  
REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARGARET MIDDLE C. LAST HONIG  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 07 86  |  | 2b. HOUR<br>11:00 PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 25 04  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 8. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY OF BALTO. MD.  |  | 10. CITY OR TOWN OF DEATH<br>BALTO CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LIBERTY MOD CENTER |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  | 13a. STATE<br>MD  |  |
| 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>BALTO.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 13e. STREET ADDRESS / ZIP CODE<br>5802 Willowton Ave. 21239   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown Horney   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-01-1868   |  | 17. INFORMANT<br>ADDRESS<br>Cockeysville, Md. 21030<br>Mrs. Fidelis C. Southard-1005 Painters La.                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>RONALD DE PULM DE</u>  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>10/07</u> , 19 <u>86</u> , to <u>10/07</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>NEVER SEEN ALIVE</u> above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><u>C. H. H. J.</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c. DATE SIGNED<br>10/07/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALEX HARMATZ   |  | 22e. ADDRESS<br>LIBERTY MOD CENTER, BALTO, MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10-9-86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville Balto. Md.  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>OCT 09 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |

00-55512

20% COLLECTION



00-20924

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial transit permit. These permits remove chapter 5, § 5-101, and 5-102 from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 6 2 8 2 5 9<br>REG. NO.  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Kathryn L. Hook  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 7, 1986                                |  |  |  | 2b. HOUR<br>10 <sup>55</sup> P.M.  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 12 22   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                            |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>DEATH HOSP. & MED. CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired-Secretary |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |  |  |   |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>Randallstown  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Potee  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Stokett                    |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-12-3139D  |  | 17. INFORMANT<br>Mrs. Mary Imwold   |  |   |  | ADDRESS<br>6101 Medora Rd.-Linthicum Hgts, Md.<br>#21090   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cancer of breast & bone<br>DUE TO, OR AS A CONSEQUENCE OF (b) metastases<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/4 1988 to 10/7 1986, that (we) last saw the deceased alive on 10/7 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Dr. Gladu   |  |  |  | DEGREE<br>M.D.  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/7/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>Oct. 15, 1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Suttas  |  |  |  | ADDRESS<br>5151 BARTO. NAT'L Pkwy # 21219   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

32 9 01 25134 10 6

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Hick" and "Hick" are visible.]*



00-21103

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert page 1 and 2 should be filed with #72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, and no medical examiner may be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | MONTH DAY YEAR  |  | 2b. HOUR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |   | JAMES W. HOOKER   |  | OCTOBER 11, 1986  |  | M  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                   |  | IF UNDER 1 YEAR  |  |
| Male   |  | Black  |   | MONTH DAY YEAR<br>5 4 21  |  | 65 YRS  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Maryland   |  | U.S.A.   |   |   |  | BALTIMORE CITY, MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | 1355 N. CALHOUN STREET   |   |   |  | N/A   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| Maryland   |  |  |   | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1355 N. Calhoun Street 21217                                   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |  |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)  |  |   |  |  |  |
| Thomas Hooker  |  |  |   | Mary Valentine  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |  |  |
| YES  |  |  |   | 218-09-1672   |  | Earl V. Hooker 2224 Garrison Boulevard                              |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung mass</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>indistinct, cachexia</u> |  |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
|  |  |  | P.M. 19   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION (CITY OR TOWN COUNTY STATE)                                      |   |  |  |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |   |   | DEGREE   |   |  | 22c. DATE SIGNED   |  |
| <u>Karen M. Lichtenfeld MD</u>   |  |  |   |   |  |   |  | 10/14/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |   | 22e. ADDRESS   |   |  |  |  |
| <u>Karen M. Lichtenfeld MD</u>   |  |  |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (CITY OR TOWN COUNTY STATE)                           |  |  |  |
| BURIAL   |  | 10/16/86   |   | Garrison Forest VA  |  | Owings Mills, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR (NAME ADDRESS)  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| March Funeral Homes 1101 East North Avenue   |  |  |   |   |  | OCT 15 1986   |  | <u>[Signature]</u>   |  |

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THE  
COLLIERIES  
OF  
THE  
WYOMING  
COAL  
FIELD

00-22755

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28261  
REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BEATRICE</b>  |  | FIRST<br><b>HORNE</b>  |  | LAST   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-29-86</b>   |  | 2b. HOUR<br><b>3:30</b> A.M.  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 1 30</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                             |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINE OPERATOR</b>     |  | 15. KIND OF BUSINESS OR INDUSTRY  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br><b>MD</b>  |  | 16b. COUNTY<br><b>BALTIMORE</b>  |  | 16c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 17. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 18. STREET ADDRESS / ZIP CODE<br><b>3425 DOLFIELD AVE 21215</b>   |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Bridges</b>   |  | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Caraway</b>  |  |  |  |  |  |   |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 22. SOCIAL SECURITY NO.<br><b>214-30-5889</b>  |  | 23. INFORMANT ADDRESS<br><b>William G. Horne 3425 Dolfield Ave</b>   |  |  |  |   |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>widely metastatic CA &amp; liver failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Breast CA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6-1984</b> |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |  |  |  |  |  |   |  |
| 25. DATE OF OPERATION   |  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 27. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 30. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 32. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 33. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 34. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 35. I certify that (I) (this hospital) attended the deceased from <b>10-21</b> , 19 <b>86</b> , to <b>10-29</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10-29</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |  |  |  |   |  |
| 36. SIGNATURE<br><b>D Boersma MD 2067</b>   |  |  |  | 37. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  |  |  | 38. DATE SIGNED<br><b>10-29-86</b>  |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. BOERSMA</b>   |  |  |  | 40. ADDRESS  |  |  |  |   |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 42. DATE<br><b>11/1/86</b>   |  | 43. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cemetery</b>   |  | 44. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                               |  |   |  |
| 45. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>March Funeral Home West 4300 Wabash Avenue</b>   |  |  |  |  |  |  |  |   |  |

MEDICAL CERTIFICATION

0073411986 Julia Gordon-Lindner



00-20827

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 2 0 2  
REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BENNETT G. HOUCK</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 10, 1986</b> |   |  | 2b. HOUR<br>A M<br><b>1:56</b>  |  |
| 1. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 8 1959</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>26</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH COUNTRY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Personnel Director</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Horses</b>  |  | 12c. ADDRESS<br><b>306 Berkeley Drive</b>   |  |   |  |   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Ann Arundel</b> 13c. CITY OR TOWN <b>Severna Park</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>306 Berkeley Drive Maryland 21146</b> |  |   |  |   |  |   |  |

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Melvin G. Houck</b>                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara S. Seibel</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>180-50-6177</b> |   | 17. INFORMANT<br><b>Melvin Houck</b> ADDRESS <b>306 Berkeley Drive Severna Park, Maryland 21146</b> |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypercalcemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lymphoma</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b><br><b>1 week</b><br><b>6 months</b> |
|--|--|---|

|  |  |
|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>④ Positive Serology for Human Immunosuppression Virus</b> |  |
|--|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> , 19 <b>86</b> , to <b>10/10</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>10/19</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Howard R. Metz MD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/10/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD R. METZ</b>  |  | 22e. ADDRESS<br><b>Tower 110 JHH 600 N Wolfe St. BALT MD</b>           |  |  |  |  |  |

|  |  |                              |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>           |  | 23b. DATE<br><b>10-14-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Plum Creek Cemetery</b>           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Plum Boro, Allegheny Pa.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>MARZULLO FUNERAL SERVICE UPPERCO, MD.</b> |  |                              |  | 25a. DATE RECD. BY REGISTRAR <b>OCT 14 1986</b> 25b. REGISTRAR'S SIGNATURE |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated with the medical record within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in by the funeral director, page 3 should be detached for use on the burial or cremation forms. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18, 19, or 20 is marked, a coroner's inquest may be required.

00-50851

260



PT 40-555  
RECEIVED  
FBI/DOJ

2


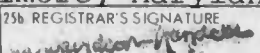


0-22399

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 8 2 6 3

|  |  |   |  |  |   |  |  |  |   |  |  |   |  |   |  |
|--|--|---|--|--|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paul Houck  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/1/86                         |  | 2b. HOUR<br>11:15P                                      |  |  |  |   |  |  |   |  |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7/27/10   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   | 8 UNDER 24 HRS<br>HOURS MIN.                             |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |   |  |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mt. Sinai Nursing Home |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----0-----   |   |  |  |   |  |   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>416 E. Eager St. 21202   |   |  |  |   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Unknown                |   |  |  | 16b. SOCIAL SECURITY NO.<br>218-58-9008 |  | 17. INFORMANT<br>ADDRESS<br>Rev. Clayton 416 E. Eager St. 21202 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CVA   |  |   |  |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH          |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  |  |   |  |  |  |   | DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____ |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10   |  |   |  |  |   |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 11/2 19 81 to 10/1 19 86, that (I) (we) saw the deceased above, (I) (we) did not see the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |   |  |  |   |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>  |  |   | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED  |  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Arthur M. Lebson, M.D.  |  |   | 22e. ADDRESS<br>3640 Fords Lane Balt, 21215                            |  |   |  |  |  |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>10/8/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |   |  |  |   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Law Funeral Home  |  |   | ADDRESS<br>4611 Park Heights Ave                                       |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1986   |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |   |  |   |  |

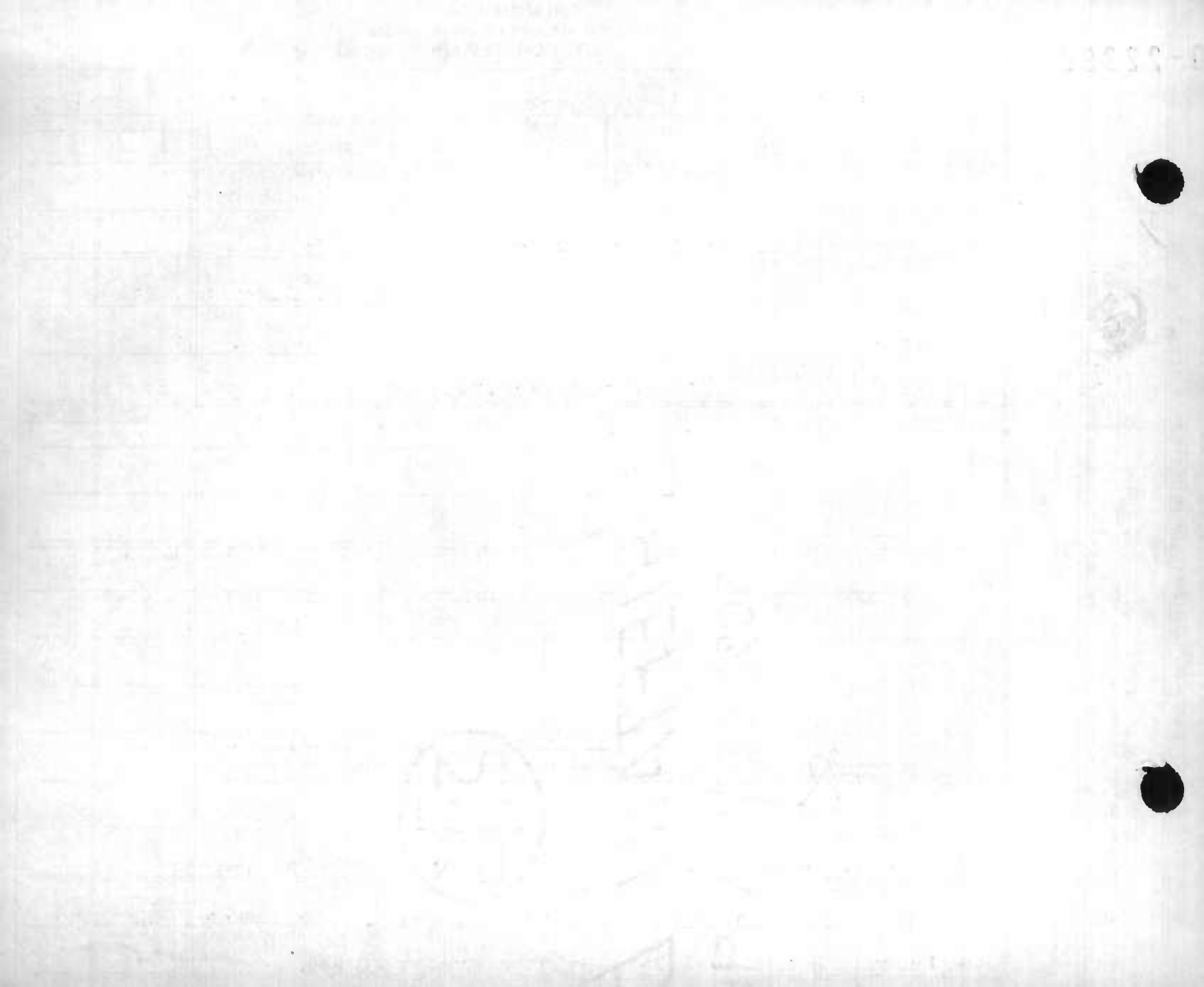
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP



00-22341

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28264

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Teresa  |  | MIDDLE<br>A.  |  | LAST<br>Houck  |  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED <input checked="" type="checkbox"/> MONTH DAY YEAR |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 7, 1963  |  | 6. AGE (IN YEARS<br>(T BIRTHDAY)<br>YRS. 23                |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 7c. DATE<br>PRONOUNCED<br>DEAD MONTH DAY YEAR<br>10/22/19 86                         |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD |  | 10. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Housewife           |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY   |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3101 Swan Drive Druid Park |  | 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>Carroll                                     |  | 13c. CITY OR TOWN<br>Finksburg   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James R. Warren   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha Beam   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214-88-8827                    |  | 17. INFORMANT<br>ADDRESS<br>Mr. Charles W. Houck Finksburg, Md.                        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Gunshot Wounds</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10/22/19 86  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>subject found shot   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>park   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3101 Swan Drive, Balto. City, Md.  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER<br>DATE SIGNED 10/23/86 |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL<br>SIGNATURE _____<br>EXAMINER'S NAME<br>(TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.  |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE<br>Oct. 25, 86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Memorial  |  | 23d. LOCATION<br>Finksburg, Md.                            |  | COUNTY   |  | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Elite Funeral Home  |  | ADDRESS<br>Reisterstown, Md. 21136   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1986  |  | 25b. REGISTRAR'S SIGNATURE                                 |  |  |  |  |  |

[illegible]

00-20373

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28265

|   |  |   |  |   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>GRACE  |  | MIDDLE<br>HOUSE   |  | LAST  |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR   |  | 7b. HOUR  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10/21/17  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>68 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10-1-86 19 10:38a   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2502 Pratt Street (W) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12d. KIND OF BUSINESS OR INDUSTRY   |  | 12e. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2502 W. Pratt St. 21223  |  | 13f. STREET ADDRESS   |  | 13g. STREET ADDRESS   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alexander Capers   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Henrietta Pearson   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>214-20-6567   |  | 17. INFORMANT<br>James House 2511 W. Forest Pk. Ave. (15)   |  | 17. ADDRESS   |  | 17. ADDRESS   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20 AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20 AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |  | 22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22c. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22d. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22e. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22f. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  | MEDICAL EXAMINER  |  | DATE SIGNED 10-1-86   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10/6/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Md.   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |  | ADDRESS<br>111 Penn Street  |  | 24 FUNERAL DIRECTOR<br>NAME<br>Chas. A. Rice FSPA   |  | ADDRESS<br>1300 Eutaw Place   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 08 1986  |  | 25b. REGISTRAR'S SIGNATURE  |  | 25c. REGISTRAR'S SIGNATURE  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00-20373



MAILED  
JAN 10 1964  
FBI - NEW YORK

00-21914

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28200

|  |                  |   |  |   |  |   |  |  |
|--|------------------|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charlotte Ann Howell  |                  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>10 15 1986 |   |  | 2b. HOUR<br>M<br>5:46A  |  |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 27, 1927  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                           | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 2c. DATE PRONOUNCED DEAD<br>October 10 15 1986                                     |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital (STU) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Rural Postal Del. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>US Postal Ser |  |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY<br>A A Co.  |  | 13c. CITY OR TOWN<br>Millersville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>(Unknown) Cole   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>(Unknown)  |  |   | 13e. STREET ADDRESS<br>474 Worthington Road 21108                                  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NA   |  | 17. INFORMANT (Husband)<br>Mr. Henry A. Howell  |  | ADDRESS<br>Same as #13  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 18.   |                  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>2:06 P.M. 9 30 1986   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Driver in truck/auto impact  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY<br>Quarterfield Rd & Donaldson Ave, Glen Burnie, A.A.CO, MD.  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |   |  |  |
| ACTUAL SIGNATURE<br>William M. Zane  |                  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | DATE SIGNED<br>10/15/86   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>William M. Zane, M.D.  |                  | ADDRESS<br>111 Penn St. Balto. MD.  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |                  | 23b. DATE<br>Oct 18, 1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process. Inc.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto. Md.                            |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Singleton Funeral Home  |                  |   |  | Glen Burnie, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]    |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-21253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|  |  |  |  |   |   |   |  |  |   |   |  |
|--|--|--|--|---|---|---|--|--|---|---|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |   | 86 28261  |  |
| 1. FOR STATE REGISTRAR   |  |  |  |   |   |   |  |  |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARY OPHELIA HUDNALL   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 10 1986 |   |  | 2b. HOUR<br>1:50 P.M.  |   |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 28 1907  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH CHARLES GENERAL HOSP. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>COOK                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>READS DRUG CO.  |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |   |   |  |  |   | 12c. BALTIMORE, MARYLAND 21215                        |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL WINSTEAD  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NANCY CAMPBELL  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO.  |   |   |  |  |   |   |  |
| 16a. SOCIAL SECURITY NO.<br>219-20-9768  |  | 17. INFORMANT<br>MRS. MADELINE MYERS BALTIMORE, MD. 21215  |  |   |   |   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) GASTRO INTESTINAL BLEEDING<br>DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>70037 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |   |   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 07/29/86 to 10/09/86, that (I) (we) lost saw the deceased alive on 10/09/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br>[Signature]  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   |   |  | 22c. DATE SIGNED<br>10/09/86   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANJARA ANJARA   |  |  |  | 22e. ADDRESS<br>NORTH CHARLES HOSPITAL<br>BALTIMORE, MD 21218   |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>ENTOMBMENT  |  | 23b. DATE<br>10/13/1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEM.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MARYLAND                               |  | 24. FUNERAL HOME<br>NUTTER + SONS FUNERAL HOME, INC.<br>2501 GWYNNS FALLS PKWY. BALTIMORE, MD 21216                        |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1986   |  |  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |   |   |  |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 28208   |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  | 2c. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2d. HOUR  |  |  |  |
| DONALD R HUDSON  |  |  |  | 10 20 86   |  |  |  | M   |  |  |  |
| 3 SEX  |  |  |  | 4 RACE   |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |  |  |
| M Male   |  |  |  | WHITE  |  |  |  | 3 8 24  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  | IF UNDER 1 YEAR  |  |  |  | IF UNDER 24 HRS   |  |  |  |
| 62 YRS.  |  |  |  | MONTHS DAYS  |  |  |  | HOURS MIN.  |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| Balto. Md.   |  |  |  | U.S.A.   |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  |
| Baltimore  |  |  |  | 507 Wickham Road 21229   |  |  |  | Retired Milk Dairy  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN   |  |  |  |
| Maryland   |  |  |  |  |  |  |  | Baltimore   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |
| William C Hudson   |  |  |  | Gladys R Mahon   |  |  |  | Yes   |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT  |  |  |  | ADDRESS   |  |  |  |
| 219 16 7066  |  |  |  | Helen A Hudson (wife)  |  |  |  | 507 Wickham Rd 21229  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>LARGE CELL CARCINOMA OF LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 wks</u>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>HYPERCALCEMIA</u>  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-25</u> , 19 <u>86</u> , to <u>10-20</u> , 19 <u>86</u> , that (I) (we) saw the deceased alive on <u>9-22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <u>Paul Gormley</u>   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED <u>10/20/86</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |  |  |
| PAUL GORMLEY   |  |  |  | 900 CATON AVE BALTO MD 21229   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |
| Burial   |  |  |  | Oct-23-86  |  |  |  | Good Shepherd   |  |  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  | 23e. DATE REC'D. BY REGISTRAR  |  |  |  | 23f. REGISTRAR'S SIGNATURE  |  |  |  |
| Ellicott City Howard Md.   |  |  |  | OCT 24 1986  |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR HARRY H. WITZKE & FAMILY 4112 OLD COLUMBIA PIKE FUNERAL HOME, INC. ELLICOTT CITY, MD., 21043  |  |  |  |  |  |  |  |   |  |  |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PLACES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28267

1- FOR  
STATE  
REGISTRAR

|   |                  |  |   |   |  |
|---|------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Larry Hughes   |                  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>10-21 1986 |   | 2b. HOUR<br>M<br>10:52                                   |
| 3. SEX<br>MALE  | 4. RACE<br>BLACK | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7-20-52  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>34 YRS.              | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10-21 1986 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE-MO   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>PRESS OPERATOR  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>PRINTING   |                  | 13a. STREET ADDRESS<br>1126 LEADER HALL ST 21201   |   | 13b. CITY OR TOWN<br>BALTIMORE  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MCKINLEY HUGHES   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNIE BETTS   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |
| 16b. SOCIAL SECURITY NO.<br>212 60 5054   |                  | 17. INFORMANT<br>Mrs Shirley Hughes  |   | ADDRESS<br>1126 LEADER HALL ST 21201  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Tamponade<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) Ruptured dissecting aneurysm of aorta<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                  |  |   |   |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |   |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.   |                  | TITLE (SPECIFY)<br>Assistant   |   | DATE SIGNED<br>10-22-86   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |                  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE 1)  |                  | 23b. DATE<br>10-27-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ARABUS MEM PIC  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD MO   |                  | 24. FUNERAL DIRECTOR<br>NAME<br>JOSEPH L. RUSS   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1986  |  |
| 25b. REGISTRAR'S SIGNATURE  |                  |  |   |   |  |

COLLECTION EFFECTS

REVIEW OF



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28270

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** Are the following items being given to the funeral director, and completely filled in by the funeral director, page 3 of the death certificate? If not, then please move the items to pages 1 and 2 should be filled within 72 hours after death.

**IMPORTANT:** If item 2 is marked or filled in by other than the medical examiner, the medical examiner must be notified by phone.

**IMPORTANT:** If item 21 is marked or item 22 checked, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

|   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>SADIE</b>  |  | MIDDLE<br><b>HUGHES</b>   |  | LAST<br><b>HUGHES</b>   |  | 2a. DATE OF DEATH<br><b>OCTOBER 24, 1986</b>  |  | MONTH<br><b>24</b>   |  | DAY<br><b>1986</b>                                   |  | 2b. HOUR<br><b>2:23</b>                          |  | A<br><b>M</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH<br><b>8</b> DAY<br><b>31</b> YEAR<br><b>31</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS<br><b></b> DAYS<br><b></b>   |  | IF UNDER 24 HRS.<br>HOURS<br><b></b> MIN.<br><b></b> |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHERS AIDE</b>           |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b></b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1428 N. DECKER ST. 21213</b>  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br><b>HENRY</b> MIDDLE<br><b></b> LAST<br><b>BRICE</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>SADIE</b> MIDDLE<br><b></b> LAST<br><b>WILLIAMS</b>   |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>21928 8418</b>   |  | 17. INFORMANT ADDRESS<br><b>THOMAS HUGHES 1428 N. DECKER ST.</b>  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>right pleural effusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>small malignant metastatic breast ca</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min</u><br><u>3 months</u><br><u>7 yrs</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><u>reactive airway disease</u>   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> , 19 <u>86</u> , to <u>10/24</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Scott Touger MD</u>  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><u>10/24/86</u>  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Scott Touger MD</u>   |  |   |  | 22e. ADDRESS<br><u>600 N. WOLFE ST. BALTO., MD</u><br><u>Johns Hopkins Hospital</u> 21205   |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10-28-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS CEMETERY</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARBUTUS MARYLAND</b>  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>MARCH FUNERAL HOMES</b>  |  |   |  | ADDRESS<br><b>1101 E. NORTH AVE</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1986</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |  |  |

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UNITED STATES GOVERNMENT  
STATIONERY OFFICE  
WASHINGTON, D. C. 20540

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 2 7 1

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lillian Hughey</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/5/86</b>                              |   | 2b. HOUR<br>M   |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MO DAY YEAR<br><b>12 21 1916</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                 |   |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>512 N. Payson St.</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b> | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                               |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Md.</b>   |   |  | 13b COUNTY<br><b>Balto.</b>  | 13c CITY OR TOWN<br><b>Balto.</b>   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eugene Wood</b>  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie Lee</b>                   |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |   | 16b SOCIAL SECURITY NO.<br><b>220 30 1055</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Louise Dailey 1100 Bolton St.</b>               |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Heartic Dysfunction and Respiratory Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Carcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>8 years</b> |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a   |   |  |  |   |   |
| 19a DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1</b> 19 <b>86</b> , to <b>Oct 5</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>September 17</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death   |   |  |  |   |   |
| 22b. SIGNATURE<br><b>Russell R. DeLuca, M.D.</b>   |   |  |  | 22c. DATE SIGNED<br><b>10/17/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Russell R. DeLuca, M.D.</b>  |   |  |  | 22e. ADDRESS<br><b>22 South Green Street, Balt., Md.</b>                      |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>10/10/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat. Mem</b>                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel Md.</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 06 1986</b>  |  |   |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>James A. Morton &amp; Sons</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |

MEDICAL CERTIFICATION

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |   |  |  |                                    |  |
|--|--|--|--|---|---|---|---|--|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John C. Hunter</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-2-86</b>                        |   |   |  |  | 2b. HOUR<br><b>10 45 PM</b>        |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 15 11</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                   |   |  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHN DEATON HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DISABLED</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |  |                                    |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                     |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4414 REISTERSTOWN RD. 21215</b> |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH HUNTER</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PRISCILLA CRAWLEY</b> |   |   |  |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-40-5856</b>                         |   | 17. INFORMANT ADDRESS<br><b>FLOSSIE HUNTER 4414 REISTERTOWN RD.</b>       |   |   |  |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Prostate cancer with metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> |  |  |  |   |   |   |   |  |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |   |   |   |  |  |                                    |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |   |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |   |  |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/23</b> , 19 <b>86</b> , to <b>10/2</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |   |  |  |                                    |  |
| 22b. SIGNATURE<br><b>Valerie Barnwell</b> MD   |  |  |  |   |   |   |   |  |  | 22c. DATE SIGNED<br><b>10/2/86</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Valerie Barnwell</b>   |  |  |  |   |   |   |   |  |  | 22e. ADDRESS                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>10-7-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD</b>                              |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MARCH FUNERAL HOMES 1101 E. NORTH AVE.</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 06 1986</b>                                 |   | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Henderson</i>   |  |                                    |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28273 REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARGARET T. HUPEELD   |   | 2a. DATE OF DEATH<br>OCT. 30. 1986  |   | 2b. HOUR<br>11:30 PM   |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>DEC. 02, 1912   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE, MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CITY   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2710 CHESLEY AVE |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>C&P TEL. CO.                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OPERATOR            |
| 13a. STATE<br>MD.  | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO. CITY  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2710 CHESLEY AVE 21234 |
| 14. FATHER'S NAME<br>FIRST M. J. MIDDLE J. LAST WHELAN   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST A. MIDDLE B. LAST BAUBERGER   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |   | 16b. SOCIAL SECURITY NO.<br>316-01-4004   |   | 17. INFORMANT<br>FAMILY RECORDS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>In situ adenoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/25</u> 19 <u>72</u> to <u>10/30</u> 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/29</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (you) (I) did not view the body after death.             |   |   |   |  |  |
| 22b. SIGNATURE<br>DONALD W. MENTZER  |   | DEGREE<br>MD.   |   | 22c. DATE SIGNED<br>11/3/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DONALD W. MENTZER   |   | 22e. ADDRESS<br>3009 EVERGREEN AVE.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |   | 23b. DATE<br>Nov. 3, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HARBORLAND MEM.                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO. CO. MD.   |   | 25a. NAME RECORD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JULIA SANDERSON RUDOLPH   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS CHAPEL OF MEMORIES   |   | ADDRESS   |   |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card immediately. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified at once.

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NOTICE

00-21498

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7. REG. NO. 86 28274   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | 20. DATE OF DEATH MONTH DAY YEAR                                    |  | 2b. HOUR                                     |  |
| FIRST MIDDLE LAST   |  | BERNARD HURT   |  | OCTOBER 15, 1986   |  | 8:01 PM   |  | A  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.       |  |
| Male  |  | Black  |  | 12 27 34   |  | 51 YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Virginia  |  | U.S.A.   |  |  |  | BALTIMORE CITY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  | Laborer  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE               |  |
| Maryland  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2324 E. Madison Street 21205                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                        |  |
| William Hurt  |  | Marie Cox  |  | Unknown  |  |   |  | Dorothy Hurt P.O. BOX 41 Meherrin, Va. 23954 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   |  | CARDIOPULMONARY FAILURE  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | SEPSIS  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  | CARCINOID CANCER OF COLON, LIVER FAILURE                            |  | 1 HOUR                                       |  |
|   |  |  |  |  |  |   |  | 10 DAYS                                      |  |
|   |  |  |  |  |  |   |  | 1 YEAR                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
| 10/3/86   |  | CARCINOID CANCER OF COLON  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
|   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/26, 19 86, to 10/15, 19 86, that (I) (we) last saw the deceased alive on 10/15/19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |  |  |
| R.S. Finney, MD   |  |  |  |  |  | 10/15/86  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| R.S. FINNEY   |  | 600 N. WOLFE ST. BALTIMORE, MD   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| BURIAL  |  | 10/20/86   |  | Eastview Memorial Pk.  |  | Baltimore, Md.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| March Funeral Homes 1101 East North Avenue  |  |  |  | OCT 20 1986  |  | John Anderson   |  |  |  |

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**K**



|   |  |  |  |   |  |   |  |   |  |                                       |  |   |  |                                   |  |                                  |  |  |  |
|---|--|--|--|---|--|---|--|---|--|---------------------------------------|--|---|--|-----------------------------------|--|----------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>LESSIE  |  | MIDDLE<br>HURTT   |  | LAST<br>HURTT   |  | 2a. DATE OF DEATH   |  | MONTH<br>10                           |  | DAY<br>04                                 |  | YEAR<br>86                        |  | 2b. HOUR<br>M                    |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH<br>9  |  | DAY<br>10   |  | YEAR<br>1920  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 |  | YRS                                       |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS |  | IF UNDER 24 HRS<br>HOURS<br>MIN. |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. CAROLINA                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |  |   |  |                                       |  |   |  |                                   |  |                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER   |  |                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME |  |                                   |  |                                  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  |   |  |   |  |                                       |  |   |  |                                   |  |                                  |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2128 ASHBURTON<br>BALTIMORE, MARYLAND 21216   |  |                                       |  |   |  |                                   |  |                                  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>DAVE  |  |  |  | MIDDLE<br>CRAWFORD, JR.   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>HANNAH                                     |  |                                       |  | MIDDLE<br>J. RHODES                       |  |                                   |  | LAST<br>RHODES                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO.             |  |  |  | 16b. SOCIAL SECURITY NO.<br>258-44-7256   |  |   |  | 17. INFORMANT<br>2128 ASHBURTON STREET<br>CHARLES E. HURTT BALTIMORE, MD. 21216 |  |                                       |  |   |  |                                   |  |                                  |  |  |  |

IMMEDIATE CAUSE (o)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

E TO, OR AS A CONSEQUENCE OF

E TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

90 DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

|                    |      |       |     |      |
|--------------------|------|-------|-----|------|
| 21b TIME OF INJURY |      |       |     |      |
| HOUR               | A.M. | MONTH | DAY | YEAR |
|                    | P.M. |       |     | 19   |

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

211 LOCATION  
STREET

CITY OR TOWN COUNTY STATE

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19 86, to \_\_\_\_\_, 19 86, that (I) (we) last saw the deceased alive on 10/14, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (this) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

ATTENDING ☒ MEDICAL ☐ STAFF  
PHYSICIAN ☒ DIRECTOR ☐ PHYSICIAN ☐

23a BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b DATE 10/09/1986

23c NAME OF CEMETERY OR CREMATORY  
LOUDON PARK CEMETERY

23d. LOCATION  
CITY OR TOWN COUNTY STATE  
BALTIMORE. MARYLAND

24. FUNERAL DIRECTOR  
NAME ADDRESS  
2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

OCT 08 1986

AR 25b REGISTRAR'S SIGNATURE

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be attached for use as the burial/transfer permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, then the medicolegal examiner must be notified at once.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medication *may* be required at once.

MEDICAL CERTIFICATION

18 shows an

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



00-21500

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28276

FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
|--|---------|--|--|---|--|---|--|--|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| ROMLISH HUTCHINSON   |         |  |  |   |  |   |  | 10 15 19 86                                  |  |                          |  |       |  |      |  | M        |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                             |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| Male   | Black   | 6 17 11  |  | 75 YRS.   |  |   |  |  |  | 10 16 19 86              |  |       |  |      |  | 12:14    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                          |  |       |  |      |  | MD.      |  |
| Georgia  |         | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  | Baltimore City                               |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                          |  |       |  |      |  |          |  |
| Baltimore  |         | 1009 N. Wolfe St.  |  | Laborer   |  | Beth Steel  |  |  |  |                          |  |       |  |      |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                          |  |       |  |      |  |          |  |
| Maryland   |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1009 N. Wolfe Street 21205                   |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| Hugh Hutchinson  |         | Mary Walker  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                          |  |       |  |      |  |          |  |
| NO   |         | 245-12-3068  |  | Japoniceker Gordon  |  | 1610 Wolfe Street   |  |  |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | Hypertensive cardiovascular disease                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |       |  |      |  |          |  |
|  |         |  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                          |  |       |  |      |  |          |  |
|  |         |  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                          |  |       |  |      |  |          |  |
|  |         |  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |                          |  |       |  |      |  |          |  |
|  |         | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
|  |         | P.M. 19  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY                                       |  | STATE                    |  |       |  |      |  |          |  |
|  |         |  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from  |         | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE SIGNED   |  | 10-16-86  |  |  |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME  |         | M.D. Assistant   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| (TYPE OR PRINT)  |         | Charles P. Kokes, M.D.   |  | ADDRESS   |  | 111 Penn St., Balto., MD  |  | 21201  |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | COUNTY                                       |  | STATE                    |  |       |  |      |  |          |  |
| BURIAL   |         | 10/21/86   |  | Md National Mem Pk..  |  | Laurel,   |  |  |  | Md.                      |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| NAME   |         | OCT 20 1986  |  | John Davidson   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| ADDRESS  |         |  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| March Funeral Homes  |         | 1101 East North Ave.   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201  
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |  |   |   |  |
|--|--|---|---|--|--|--|---|---|--|
| 1- FOR STATE REGISTRAR   |  |   |   |  |  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) Anna Maryjane Iannicelli  |  |   |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 10 09 86  |   | 2b. HOUR 17:07  |  |
| 3. SEX Female  |  | 4. RACE White   |   | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 3 18  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.  |   | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker  |   | 12b. KIND OF BUSINESS OR INDUSTRY ---   |  |
| 13a. STATE Maryland  |  | 13b. COUNTY ---   |   | 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE 1234 Grantley Street, 21229  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank --- Catano   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |   |   | 16b. SOCIAL SECURITY NO. 213-03-8948   |  | 17. INFORMANT ADDRESS Vincent Stapleton, 2513 Thornberry Drive   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> (b) <i>As a consequence of Chronic Hypertensive Heart</i> (c) <i>Chronic Arteriosclerosis</i>   |  |   |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/8 to 10/9, 1986, that (I) (we) last saw the deceased alive on 10/9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |   |   |  |
| 22b. SIGNATURE <i>John Healy</i>   |  |   | DEGREE  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED 10/9/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Healy, M.D.   |  |   | 22e. ADDRESS Saint Agnes Hosp 900 Caton Ave Balto Md 21229          |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 10/13/86  |   | 23c. NAME OF CEMETERY OR CREMATORY Crestlawn Gar.Of Mem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard Md.  |   |   |  |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave.  |  |   | 24b. ADDRESS 21229  |  | 25a. DATE REC'D. BY REGISTRAR 10/15/1986                                       |  | 25b. REGISTRAR'S SIGNATURE <i>William R. H. H. H.</i> |   |  |

BP

16208-

00-20817

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PARTS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG-28278

|  |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
|--|--|---|--|------------------------------------|----------------------------------|--|-----------|--------------------------|----------|-------------------|----------|-------------|--|
| 1. FOR STATE REGISTRAR   |  | 2. DATE KNOWN OF DEATH                            |  | 3. MONTH                           |                                  | 4. DAY                                     |           | 5. YEAR                  |          | 6. HOUR           |          |             |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2. DATE KNOWN OF DEATH                            |  | 3. MONTH                           |                                  | 4. DAY                                     |           | 5. YEAR                  |          | 6. HOUR           |          |             |  |
| Michael J. Ingersoll   |  | 10-8  |  | 19                                 |                                  | 86   |           |                          |          | 3:50 a.m.         |          |             |  |
| 7. SEX   | 8. RACE  | 9. DATE OF BIRTH                                  | 10. AGE (IN YEARS)   | 11. IF UNDER 1 YR.                 | 12. IF UNDER 24 HRS.             | 13. DATE PRONOUNCED DEAD                   |           | 14. MONTH                |          | 15. DAY           |          |             |  |
| Male   | White  | June 5 1964                                       | 22 YRS.  |                                    |                                  | 10-8                                       |           | 19                       |          | 86                |          |             |  |
| 16. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 17. CITIZEN OF WHAT COUNTRY?                             | 18. MARRIED                                       |  | 19. NEVER MARRIED                  |                                  | 20. BALTIMORE CITY OR COUNTY OF DEATH      |           | 21. MONTH                |          | 22. DAY           |          |             |  |
| New York   | U.S.A.   | WIDOWED   |  | DIVORCED                           |                                  | Baltimore City,                            |           |                          |          |                   |          |             |  |
| 23. CITY OR TOWN OF DEATH  | 24. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   | 25. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                    | 26. KIND OF BUSINESS OR INDUSTRY |  | 27. MONTH |                          | 28. DAY  |                   | 29. YEAR |             |  |
| Baltimore  | University Hospital - STU                                |   | Nurses Aide  |                                    | State Hosp.                      |  |           |                          |          |                   |          |             |  |
| 30. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)   | 31. CITY OR TOWN   | 32. INSIDE CITY LIMITS?                           | 33. STREET ADDRESS   |                                    | 34. MONTH                        |  | 35. DAY   |                          | 36. YEAR |                   | 37. HOUR |             |  |
| Maryland   | Carroll  | YES   | P.O. Box 100   |                                    | 21784                            |  |           |                          |          |                   |          |             |  |
| 38. FATHER'S NAME  | 39. MOTHER'S MAIDEN NAME                                 | 40. SOCIAL SECURITY NO.                           |  | 41. INFORMANT                      |                                  | 42. ADDRESS                                |           | 43. MONTH                |          | 44. DAY           |          | 45. YEAR    |  |
| Harvey Ingersoll   | Karen Miller   | 059-60-3217                                       |  | Robert Barnes                      |                                  | 12509 Indian Hill Dr. Sykesville, MD 21784 |           |                          |          |                   |          |             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| PART I DEATH WAS CAUSED BY:  |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| IMMEDIATE CAUSE (a) Stab Wound of Chest  |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| (c)  |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)             |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  | 20. AUTOPSY?                       |                                  | 21. YES                                    |           | 22. NO                   |          | 23. DATE          |          | 24. TIME    |  |
|  |  |   |  |                                    |                                  | YES  |           | NO                       |          | 10-8-86           |          | 10-8-86     |  |
| 25a. EXTERNAL CAUSE WAS UNDERLYING   |  | 25b. TIME OF INJURY                               |  | 25c. HOW INJURY OCCURRED           |                                  | 26a. PLACE OF INJURY                       |           | 26b. STREET              |          | 26c. CITY OR TOWN |          | 26d. COUNTY |  |
| CONTRIBUTING CAUSE OF DEATH  |  | ? P.M. 10-8 1986                                  |  | subject stabbed himself            |                                  | hospital                                   |           | Springfield State Hosp., |          | Carroll Co.,      |          | Md.         |  |
| 27a. INJURY OCCURRED WHILE AT WORK   |  | 27b. PLACE OF INJURY                              |  | 27c. STREET                        |                                  | 27d. CITY OR TOWN                          |           | 27e. COUNTY              |          | 27f. STATE        |          | 27g. DATE   |  |
| XX NOT WHILE AT WORK   |  | hospital  |  | Springfield State Hosp.,           |                                  | Carroll Co.,                               |           | Md.                      |          |                   |          | 10-8-86     |  |
| 27a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| Natural causes, Accident, Suicide, Homicide, Undetermined manner.  |  |   |  |                                    |                                  |  |           |                          |          |                   |          |             |  |
| 28a. SIGNATURE   |  | 28b. TITLE (SPECIFY)                              |  | 28c. MEDICAL EXAMINER              |                                  | 28d. DATE SIGNED                           |           | 28e. MONTH               |          | 28f. DAY          |          | 28g. YEAR   |  |
| Dennis F. Smyth, M.D.  |  | Assistant   |  |                                    |                                  | 10-8-86                                    |           |                          |          |                   |          |             |  |
| 29a. EXAMINER'S NAME   |  | 29b. ADDRESS                                      |  | 29c. DATE REC'D. BY REGISTRAR      |                                  | 29d. REGISTRAR'S SIGNATURE                 |           | 29e. MONTH               |          | 29f. DAY          |          | 29g. YEAR   |  |
| Dennis F. Smyth, M.D.  |  | 111 Penn St., Balto., Md. 21201                   |  | OCT 14 1986                        |                                  |  |           |                          |          |                   |          |             |  |
| 30a. BURIAL, CREMATION, REMOVAL  |  | 30b. DATE   |  | 30c. NAME OF CEMETERY OR CREMATORY |                                  | 30d. LOCATION                              |           | 30e. COUNTY              |          | 30f. STATE        |          | 30g. YEAR   |  |
| Burial   |  | 11 Oct 86   |  | Lowville Rural Cem.                |                                  | Lowville                                   |           | Lewis                    |          | N.Y.              |          | 1986        |  |
| 31a. FUNERAL DIRECTOR  |  | 31b. ADDRESS                                      |  | 31c. DATE REC'D. BY REGISTRAR      |                                  | 31d. REGISTRAR'S SIGNATURE                 |           | 31e. MONTH               |          | 31f. DAY          |          | 31g. YEAR   |  |
| SLACK Funeral Home   |  | Box 268 Ellicott City, MD 21043                   |  | OCT 14 1986                        |                                  |  |           |                          |          |                   |          |             |  |





00-20057

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 28279

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WESLEY</b>   |  | FIRST <b>WESLEY</b> MIDDLE <b>C.</b> LAST <b>INGRAM SR.</b>  |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>6</b> YEAR <b>86</b> HOUR <b>3:30</b> MIN. <b>A</b>  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>November</b> DAY <b>9</b> YEAR <b>1909</b>  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7a. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION (WORKING LIFE)<br><b>Electronics Technician</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  |
| 14. FATHER'S NAME FIRST <b>William</b> MIDDLE LAST <b>Ingram</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Ona</b> MIDDLE LAST <b>Willey</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |
| 17. SOCIAL SECURITY NO.<br><b>223-14-6941</b>   |  | 18. INFORMANT<br><b>Isabelle Ingram</b>  |  | 19. ADDRESS<br><b>Same as # 13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEVERE CHRONIC OBSTRUCTIVE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>CORONARY ARTERY DISEASE WITH CARDIAC ARRHYTHMIAS</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (b) (this hospital) attended the deceased from <b>8/7</b> 19 <b>79</b> to <b>DEATH</b> 19 <b>86</b> , that (b) (we) lost saw the deceased alive on <b>10/2/86</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Albin D. Kuhn MD</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>10/6/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBIN KUHN MD</b>   |  | 22e. ADDRESS<br><b>1001 PINE HEIGHTS AVE, BAZZ, MD 21229</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>10/8/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  | 24. FUNERAL DIRECTOR<br><b>Letoy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 06 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

24. FUNERAL DIRECTOR

1630 Edmondson Avenue, Catonsville, MD. 21228

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

95580

18

10-50025

8

00-19955

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 86 28280

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NATHAN C. IRBY SR.   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 1, 1986                                     |  | 2b. HOUR<br>5:22 A.M.  |
| 3. SEX<br>Male  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 9 04  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                                |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOME HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Urban Housing   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Irby   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Owens                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>219-01-1180A  |  | 17. INFORMANT<br>ADDRESS<br>Martha Branch 1518 N. Broadway                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <del>CEREBROVASCULAR ACCIDENT</del><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 MONTHS   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>PNEUMONIA, DECUBITUS ULCERS   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 15, 1986, to OCTOBER 1, 1986, that (I) (we) last saw the deceased alive on OCTOBER 1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)  |   |   |  |  |  |
| 22b. SIGNATURE<br>Paul Gormley  |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>10/1/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL GORMLEY, M.D.   |   | 22e. ADDRESS<br>100 N. BROADWAY<br>BALTIMORE, MARYLAND 21231  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>BURIAL  |   | 23b. DATE<br>10/6/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Homes   |   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>OCT 03 1986 John Swider-Rodell |  |  |

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00-10022



00-22478

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28281  
REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA F. ISAACS</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 22, 1986</b>                       |  | 2b. HOUR<br><b>8 A.</b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 28, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6503 PARK HEIGHTS AVE., APT. 2D</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                  |  |
| 13a. STATE<br><b>MARYLAND</b>   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br><b>GETZEL</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br><b>MARYASSA ERNST</b>                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>220-44-4088</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. EVELYN OIDICK 7929 WINTERSET AVE. 21208</b>         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cachexia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Suspected intra-abdominal cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b><br><b>1 year</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) <b>this hospital</b> provided <b>June 16, 1986</b> to <b>Oct 22, 1986</b> , that (I) <b>last</b> saw the deceased alive on <b>Oct 21, 1986</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>have</b> (did) (did not) view the body after death.                               |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Marvin Goldstein, MD</b>   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>Oct 23, 1986</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARVIN GOLDSTEIN</b>  |   | 22e. ADDRESS<br><b>6001 Park Heights Ave. 21215</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>10/24/86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH CEMETERY</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1986</b>                                  |  |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or transfer.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





0-20836

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 8 2 8 2 8 2  
REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| DECEASED NAME (TYPE OR PRINT)<br><b>DESSIE ANDERSON IULA</b>  |   | OCTOBER 9, 1986   |   | 64 M   |  |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 23, 1888</b>  |   | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>97</b>                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3811 Canterbury Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3811 Canterbury Rd. 21218</b>             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles H. Anderson</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Estelle Cromwell</b>                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-76-7816</b>   |   | 17. INFORMANT ADDRESS<br><b>Doris Anderson Stude Same</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ATHEROSCLEROTIC CEREBRAL VASCULAR DIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 DAYS</b><br><b>10 YEARS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>30 OCT 19 84</b> to <b>9 OCT 19 85</b> , that (I) (we) lost saw the deceased alive on <b>9 OCT 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |   |   |   |  |  |
| 22b. SIGNATURE<br><b>J. Dixon Hills</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>10 OCT 86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Dixon Hills, M.D.</b>  |   | 22e. ADDRESS<br><b>3501 St. Paul St. Baltimore, Md. 21218</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |   | 23b. DATE<br><b>Oct. 11, 1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Baltimore Co., Md.</b>   |   | 23e. DATE REG'D. BY REGISTRAR<br><b>OCT 14 1986</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc.</b>  |   | ADDRESS<br><b>6500 York Rd. Balto., Md. 21212</b>   |   | 25a. DATE REG'D. BY REGISTRAR<br><b>OCT 14 1986</b>                            |  |
| 25b. REGISTRAR'S SIGNATURE  |   |   |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-22795

|  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8628283   |  |
| 1- FOR STATE REGISTRAR   |  | DECEASED NAME (TYPE OR PRINT)<br><b>George IVANECT</b>   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>October 22, 1986</b>                          |  |  |  | 2b HOUR<br><b>12:00p<sub>M</sub></b>                            |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 1 19</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>  |  | IF UNDER 24 HRS HOURS MIN<br><b>0 0</b>                         |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltikore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>      |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Shipbuilding</b>  |  |   |  |
| 13a STATE<br><b>Md.</b>  |  |  |  | 13b COUNTY<br><b>Balto.</b>   |  | 13c CITY OR TOWN<br><b>Balto.</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>18 W. Preston St. 21201</b> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>George Ivaneck</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Marie</b>   |  |   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b SOCIAL SECURITY NO.<br><b>WWII</b>   |  | 17 INFORMANT ADDRESS<br><b>Mrs. Louise Ivaneck Balto., Md. 1615 Park Ave.</b>   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Liver Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholism</b>  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>1a</b>   |  |  |  |   |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |  |   |  |  |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 21, 1986</b> to <b>October 22, 1986</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 22, 1986</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |
| 22b SIGNATURE<br><i>William Tan</i>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c DATE SIGNED<br><b>10/23/86</b>   |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William Tan, M.D.</b>   |  |  |  | 22e ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  | 23b DATE<br><b>10-27-86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Anatomy Board</b>   |  |  |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>OCT 31 1986</b>                                  |  | 25b REGISTRAR'S SIGNATURE<br><i>Julia Dendron-Rudner</i>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be accompanied by a detailed report.

60-25672

DEL 8 1 1968 (100-100000-100000)

00-22525

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28284

FOR  
1- STATE  
REGISTRAR

|  |         |  |  |   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
|--|---------|--|--|---|--|------------------------------------|--|--|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST                               |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH                    |  | DAY   |  | YEAR |  | 7b. HOUR |  |
| ANDREW JACKSON   |         |  |  |   |  |                                    |  | 10-23-86                                     |  |                          |  |       |  |      |  | M        |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                     |  | IF UNDER 24 HRS.                             |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| Male   | Black   | 12/25/43   |  | 42 YRS.   |  |                                    |  |  |  | 10-23-86                 |  |       |  |      |  | 9:17P    |  |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7e. CITIZEN OF WHAT COUNTRY?                               |  | 8. MARRIED  |  | NEVER MARRIED                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                          |  |       |  |      |  | MD       |  |
| Alabama  |         | USA  |  | WIDOWED   |  | DIVORCED                           |  | Baltimore City                               |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                          |  |       |  |      |  |          |  |
| Baltimore  |         | University Hospital STU                                    |  | Labourer  |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?           |  | 13e. STREET ADDRESS                          |  |                          |  |       |  |      |  |          |  |
| md   |         |  |  | Baltimore   |  | YES                                |  | 13192 Edmondson Ave                          |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                   |  |   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| Andrew Jackson   |         | Mary Parker  |  |   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                   |  | 17. INFORMANT   |  | ADDRESS                            |  |  |  |                          |  |       |  |      |  |          |  |
| no   |         |  |  | Mary Tender   |  | 806 Lexington ST                   |  |  |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART I DEATH WAS CAUSED BY:                                |  | IMMEDIATE CAUSE (a)   |  | GunsHOT wound of chest and abdomen |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |       |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                  |         |  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF     |  |  |  |                          |  |       |  |      |  |          |  |
|  |         |  |  | (c)   |  | DUE TO, OR AS A CONSEQUENCE OF     |  |  |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |         |  |  |   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?          |  | 20. AUTOPSY?  |  | YES                                |  | NO   |  |                          |  |       |  |      |  |          |  |
|  |         |  |  |   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| 8:56P.M. 10-23-86  |         | subject shot   |  |   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK   |         | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  | CITY OR TOWN                       |  | COUNTY                                       |  | STATE                    |  |       |  |      |  |          |  |
| NOT WHILE AT WORK  |         | street   |  | 500blk. N. Gilmore St.  |  | Baltimore                          |  | Maryland                                     |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                 |         | Autopsy  |  | Inspection  |  | Inquiry                            |  | and in my opinion                            |  |                          |  |       |  |      |  |          |  |
| Natural causes   |         | Accident   |  | Suicide   |  | Homicide                           |  | Undetermined manner                          |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | M.D.  |  | MEDICAL EXAMINER                   |  | DATE SIGNED                                  |  |                          |  |       |  |      |  |          |  |
| Margarita A. Korell  |         | M.D.   |  | 111 Penn Street   |  |                                    |  | 10-24-86                                     |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |  |   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| Margarita A. Korell  |         |  |  |   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |
| 23a. METHOD OF CREMATION, REMOVAL  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                      |  | CITY OR TOWN                                 |  | COUNTY                   |  | STATE |  |      |  |          |  |
| Burial   |         | 10/31/86   |  | Mt Zion   |  | Landowne                           |  | Balto.                                       |  | Md                       |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE         |  |  |  |                          |  |       |  |      |  |          |  |
| Russell B. Allen   |         | 163 Druid Hill   |  | OCT 29 1986   |  |                                    |  |  |  |                          |  |       |  |      |  |          |  |

RECEIVED

1944

MINIATURE



1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1, 2, and 3, and file them in the file of the deceased. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. A physician's certificate must be kept on file at all times.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                            |  |  |  |                                   |   |  |
|--|--|---|--|---|----------------------------|--|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LUTHER W. JACKSON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 07 86</b> |   | 2b. HOUR<br><b>4:30 AM</b> |  |  |  |                                   |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 14 20</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                   | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Local 557</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY   |                            | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   | 13e. STREET ADDRESS / ZIP CODE<br><b>2503 Violet Avenue Apt. 709 21215</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Jackson</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Roberts</b>   |                            |  |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>226164959</b>  |                            | 17. INFORMANT<br>ADDRESS<br><b>Marietta V. Jackson 2503 Violet Ave. Apt. 709</b>     |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>RENAL FAILURE</b><br>(c) <b>RENAL FAILURE</b> |  |   |  |   |                            |  |  |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |                            |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                            |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>0909 86 10/07 86</b>         |  |  |                                   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>10/07 19 86</b> to <b>10/07 19 86</b> , that (I) (we) last saw the deceased alive on <b>10/07 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |                            |  |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>Kuang-yen Huang MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |                            |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br><b>10/07 86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>  |  |   |  | 22e. ADDRESS<br><b>Bon Secours Hospital</b>   |                            |  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>10/11/86</b>  |                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Maryland</b>  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March Funeral Home Inc. 1101 E. North Ave</b>  |  |   |  |   |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1986</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. A. Davidson</b>  |                                   |   |  |

BP

20% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28280

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Viola JACKSON  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 04 86  |  | 2b. HOUR<br>10:00 P.M.  |  |
| 3 SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 1 1916   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br>70   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Unemployed  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Allen  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Hattie Green  |  | 13e. STREET ADDRESS / ZIP CODE<br>2574 Hollins St 21223   |  | Apt 4   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-18-0764B  |  | 17. INFORMANT ADDRESS<br>Willie Jackson 2574 Hollins St Apt 4   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>191 82 10 86  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/1 to 10/4, 1986, that (I) (we) last saw the deceased alive on 10/4, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Kuang-yen Huang   |  | DEGREE M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>10/5/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KUANG-YEN HUANG  |  | 22e. ADDRESS<br>Bon Secours Hospital  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10/8/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Vet   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Owings Mills MD  |  |
| 24. FUNERAL DIRECTOR NAME<br>March Funeral Home West 4300 Wabash Avenue   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>10/10/86   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |  |

BP





00-22599

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 0 2 8 2 8

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |  |
|---|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MELODY L. JAMES</b>  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 28, 1986</b>  |   | 7b. HOUR<br><b>2:40 a.m.</b>   |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 15 53</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>33</b> YRS  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MARYLAND GENERAL HOSPITAL</b> |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b> | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Bakery</b>  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b> |   | 13b COUNTY<br><b>Baltimore</b>  | 13c CITY OR TOWN<br><b>Baltimore</b>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John G. Bierner</b>   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Freda M. Brown</b>   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-62-0284</b>  | 17 INFORMANT<br>ADDRESS<br><b>John G. Bierner Same as 13e</b>   |   |  |

|  |  |  |
|--|--|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC RENAL FAILURE</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 years</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC PYLONEPHRITIS</b>   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **CONGESTIVE HEART FAILURE, INTESTINAL OBSTRUCTION**

|  |   |   |  |
|--|---|---|--|
| 19a DATE OF OPERATION  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 22, 19 86</b> to <b>October 28, 19 86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 28, 19 86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death. |   |   |  |
| 22b SIGNATURE<br><b>James Kelly</b>  | DEGREE<br><b>DO</b>   | 22c DATE SIGNED   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Kelly</b>   | 22e ADDRESS<br><b>c/o MARYLAND GENERAL HOSPITAL</b>                   |   |  |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>            | 23b DATE<br><b>10/31/86</b> | 23c NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Park</b> | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md</b> |
| 24 FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy Balto Md</b> |                             | 25a DATE REC'D. BY REGISTRAR<br><b>OCT 30 1986</b>              | 25b REGISTRAR'S SIGNATURE   |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28289

|  |  |   |   |   |  |  |  |  |                                   |  |  |
|--|--|---|---|---|--|--|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLAUDETTE J. JANOWIAK</b> |  |   | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>4</b> YEAR <b>86</b> |   |  | 2b. HOUR<br><b>12-05P</b> M.   |  |  |                                   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>14</b> YEAR <b>36</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |                                   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |

|   |  |  |                              |  |  |                   |  |  |   |  |  |  |  |  |
|---|--|--|------------------------------|--|--|-------------------|--|--|---|--|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> |  |  | 13b. COUNTY <b>Baltimore</b> |  |  | 13c. CITY OR TOWN |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1700 Ryewood Road 21234</b> |  |  |
|---|--|--|------------------------------|--|--|-------------------|--|--|---|--|--|--|--|--|

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 14. FATHER'S NAME<br>FIRST <b>George B.</b> MIDDLE <b>Sterling</b> LAST |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret Regina</b> MIDDLE <b>Webster</b> LAST |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>215-30-6970</b> |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Walter W. Janowiak 26 Shawnee Ct. Apt 101</b> |  |  |  |
|---|--|--|--|--|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Resp. Artn.</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Mekashtie Adeno CA. widespread.</b>  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>COPD</b>   |  |   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 9a. DATE OF OPERATION   |  | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/29/86</b> to <b>9/4/86</b> , that (I) (we) last saw the deceased alive on <b>9/4/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) <b>move the body after death.</b> |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>S. Srinivas</b>  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>9/4/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUBRAMANIAN SRINIVAS.</b>   |  | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSP. BLD. #208<br/>BALTIMORE MD 21239</b>   |  |  |  |   |  |

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> |  | 23b. DATE<br><b>9/6/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE |  |
|--|--|----------------------------|--|--|--|---|--|

|  |  |   |  |                            |  |
|--|--|---|--|----------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>5305 Harford Road 21214</b> |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 5 1986</b> |  | 25b. REGISTRAR'S SIGNATURE |  |
|--|--|---|--|----------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the coroner should be notified at once.

MEDICAL CERTIFICATION

0-17184

23814 NOTION 2002

Edward J. Beck, Inc. 7502 Harford Road 21214

Baltimore Maryland

00-22080

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 8 2 8 9  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WARREN</b>          |  |  | FIRST MIDDLE LAST<br><b>JEFFERSON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 11 86</b>  |  |  | 2b. HOUR<br><b>4:30 AM</b>  |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 28 24</b>  |  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>62</b> YRS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>       |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                 |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LOCH RAVEN V.A. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bricklayer</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |  |
| 13a. STATE<br><b>MD</b>                                       |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gilmore</b>      |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Thelma Tuck</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>224-28-3736</b>  |  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Fifth Ave. and Post 40 Rd.</b> |  |  | 17. INFORMANT<br><b>Mr. Harry B. Jefferson Glen Burnie, Md.</b>  |  |  |   |  |  |   |  |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY  |  |  |  |
| IMMEDIATE CAUSE (a) <b>Respiratory arrest</b>                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| (b) <b>end stage head and neck carcinoma</b>                             |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| (c)  |  |  |  |

|  |  |  |  |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |
| 9a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-10</b> , 19 <b>86</b> , to <b>10-11</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10-11</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |
| 22a. SIGNATURE<br><b>N. ERIC CARNELL</b>   |  | 22c. DATE SIGNED<br><b>10-11-86</b>  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>N. ERIC CARNELL</b>  |  | 22e. ADDRESS<br><b>Loch Raven V.A. Hospital Balt. 21218</b>  |  |

|  |  |                              |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b> |  | 23b. DATE<br><b>10-12-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>           |  |                              |  | ADDRESS<br><b>Balto., Md.</b>                              |  | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1986</b> |  |
|  |  |                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Randall</b> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please forward this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or both 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

2-10-1968

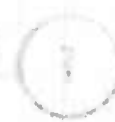
March 1968

March 1968  
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 March 1968

00-19997

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11b, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (15))

| FOR<br>STATE<br>REGISTRAR   |  |                         |  |  |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH             |  |   |  |  |  |                          |  |  |  | REG. NO. 28290 |  |
|---|--|-------------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|--------------------------|--|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LILLIE MAE JEFFRIES</b>  |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH DAY YEAR  |  | 2b. HOUR                                     |  |                          |  |  |  |                |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 14 08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78 YRS.</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br><b>10-1-86</b>  |  | MONTH DAY YEAR                               |  | 2d. HOUR<br><b>5:10A</b> |  |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                       |  |  |  |                          |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3217 Mondawmin Avenue</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>                    |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |                          |  |  |  |                |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY             |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3217 Mondawmin Avenue 21216</b>   |  |  |  |   |  |  |  |                          |  |  |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |                         |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |  |  |                          |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-22-4640A</b>  |  |   |  | 17. INFORMANT ADDRESS<br><b>James A. Jeffries 9 Westerlee Drive</b>   |  |  |  |   |  |  |  |                          |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.  |  |                         |  |  |  |   |  |   |  |  |  |   |  |  |  |                          |  |  |  |                |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                          |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |  |  |                          |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |                          |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held in Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |  |  |   |  |  |  |                          |  |  |  |                |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |  |   |  |  |  | DATE SIGNED<br><b>10-1-86</b>   |  |  |  |                          |  |  |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |   |  |  |  |   |  |  |  |                          |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>10/7/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                                 |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                            |  |   |  |  |  |                          |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>March Funeral Homes 1101 East North Avenue</b>   |  |                         |  |  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 06 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Dennis F. Smyth</i>                                |  |  |  |                          |  |  |  |                |  |

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00-22737

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 2 9 1  
REG. NO.

|  |  |  |   |   |                       |  |  |
|--|--|--|---|---|-----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE J. LAST JENKINS |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-29-86 |   | 2b. HOUR<br>2:00 P.M. |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-06-98  |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87<br>YRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. CITY MD.               |  |
| 10. CITY OR TOWN OF DEATH<br>BALT  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERIDIAN LONG GREEN |   |   |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR WORKING LIFE)<br>Housewife |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic                            |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |   | 13b. STREET ADDRESS<br>115 East Melrose Ave.  |                       |  |  |

|   |  |   |  |
|---|--|---|--|
| 14. FATHER'S NAME<br>Michael  |  | 15. MOTHER'S MAIDEN NAME<br>Schaaf<br>Unknown |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>N/A |  | 16b. SOCIAL SECURITY NO.<br>297-10-4392       |  |
| 17. INFORMANT<br>Edward D. Miller   |  | ADDRESS<br>903 Joppa Farm Road Joppa, MD.     |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ASCVD |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |

22a. I certify that (I) (this hospital) attended the deceased from APRIL 22, 1986, to OCT 29, 1986, that (I) (we) last saw the deceased alive on OCT 8, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|   |  |  |  |                              |  |
|---|--|--|--|------------------------------|--|
| 22b. SIGNATURE<br>Marcio M. Menendez MD                     |  | DEGREE<br>MD                                 |  | 22c. DATE SIGNED<br>10/29/86 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARCIO M. MENENDEZ |  | 22e. ADDRESS<br>5820 YORK RD BALTO. MD 21212 |  |                              |  |

|  |  |                      |  |   |  |   |  |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>11-1-86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Akron Summit Ohio |  |
|--|--|----------------------|--|---|--|---|--|

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| 24. FUNERAL DIRECTOR<br>MARZULLO FUNERAL SERVICE, UPPERCRO, MD |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1986 |  | 25b. REGISTRAR'S SIGNATURE |  |
|--|--|--|--|----------------------------|--|

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial transit permit. Then please deliver carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



22531

00-22112

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28292

1- FOR  
STATE  
REGISTRAR

|  |   |   |   |  |
|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET JENNINGS</b>   |   | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>22</b> YEAR <b>86</b>   |   | 2b. HOUR<br><b>2:00</b> M  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>BLACK</b>                   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>9</b> YEAR <b>13</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>                                 |
| 7. BIRTHPLACE<br>(COUNTRY)<br><b>Va</b>  | 8. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD  |   | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b>  |   | 12a. USUAL OCCUPATION<br>(WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md</b>  | 13b. COUNTY<br><b>Baltimore</b>           | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3800 W. Belvedere Ave 21215 Apt 716</b> |
| 14. FATHER'S NAME<br>FIRST <b>Goldie</b> MIDDLE <b>A.</b> LAST <b>Ricks</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>EMMA</b> MIDDLE <b>Barmar</b> LAST <b>Barmar</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>224-50-5071</b>  |   | 17. INFORMANT<br><b>Edith Moore</b> ADDRESS<br><b>3402 Glen Ave</b>          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary heart failure</b> |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Coronary heart failure</b>  |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   | 22a. I certify that (I) (this hospital) attended the deceased from <b>10/22/86</b> to <b>10/22/86</b> that (I) (we) lost<br>saw the deceased alive on <b>10/22/86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |  |
| 22b. SIGNATURE<br><b>M. K. Homan</b>   |   | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. K. Homan</b>  |   | 22e. ADDRESS<br><b>Bon Secours Hospital</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>10/27/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>             |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co Md</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>March Funeral Home West 4300 Wabash Avenue</b>   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE  |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)

HEBIB MUTOO 2909

CHIEF WINTER



00-20282

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28293  
REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Preston</i> <i>Jennings Jr.</i> |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10</i> <i>15</i> <i>86</i>  |  | 2b. HOUR<br><i>12 A</i> M  |  |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>Black</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>04-03-14</i>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br>COUNTRY<br><i>Baltimore MD</i>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>72</i> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lafayette Square Nsg Center</i> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i> |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Preston</i> <i>Jennings</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ESTER</i> <i>CRAGE</i> |  | 13d. STREET ADDRESS / ZIP CODE<br><i>291 S. Ballou Court 21231</i> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>UNKNOWN</i>                                   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><i>Rebecca Jones</i>                              |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ischemic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/73</i> 19 <i>81</i> to <i>10/5</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>10/29</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE<br><i>MD</i>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>10/6/86</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Moges Gebremama</i>  |  |  |  | 22e. ADDRESS   |  |   |  |

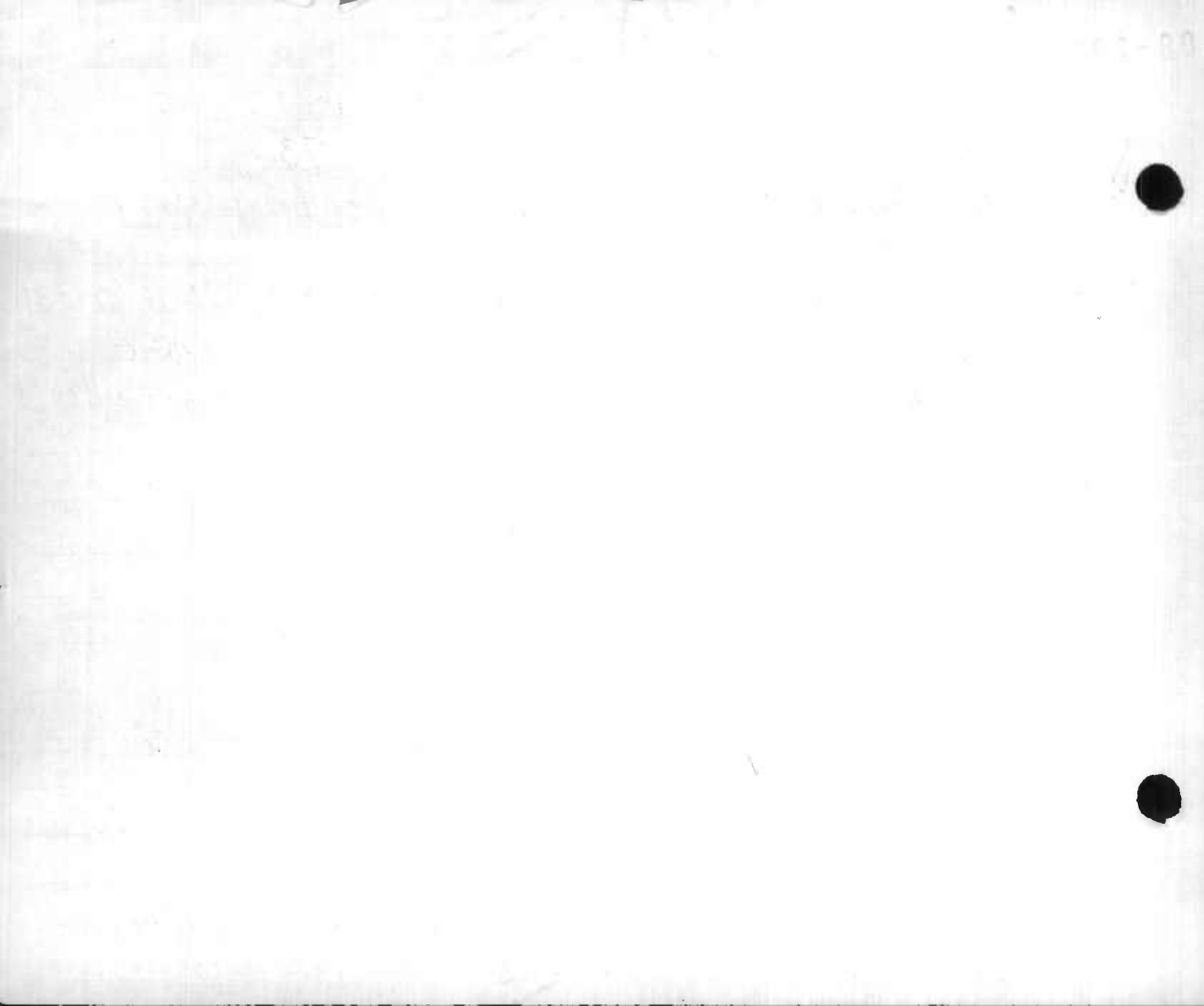
|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i> |  | 23b. DATE<br><i>10-10-86</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MT. AUBURN Cem.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Benny Thompson F.H.</i>    |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 08 1986</i>          |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

00-21981

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 REG. NO. 2 8 2 9 4

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BOYCE</b> <b>(J.)</b> <b>JETER</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 21 1986</b>                                      |  | 2b. HOUR <b>6:48 P.M.</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 14 1900</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SC</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LAWRENCE JETER</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MYRAH ?</b>                              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-10-0510</b>  |  | 17. INFORMANT ADDRESS<br><b>JEANETTE R. JETER 3218 GULFPORT DR.</b>                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASPIRATION PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RESECTION OF MANDIBLE DUE TO CARCINOMA OF NASOPHARYNX, ISCHEMIC HEART DISEASE</b>   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>HOURS</b><br><b>WEEKS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>RESECTION OF MANDIBLE DUE TO CARCINOMA OF NASOPHARYNX, ISCHEMIC HEART DISEASE</b>  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/12</b> 19 <b>86</b> , to <b>10/21</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/21</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Michael Shortan</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10/21/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL SHORTAN</b>  |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL 900 LOAN AVE BALTIMORE</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-25-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEMETERY</b>                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY BALTIMORE MD</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1986</b>   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MARCH F/H 1101 E. North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1986</b>   |  |  |   |
| 25b. REGISTRAR'S SIGNATURE   |  | 25c. REGISTRAR'S SIGNATURE  |  |  |   |

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 28295

|  |  |  |  |  |  |   |  |                                      |  |  |  |
|--|--|--|--|--|--|---|--|--------------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT)                            |  | FIRST MIDDLE LAST  |  | 2a DATE KNOWN OF DEATH  |  | MONTH DAY YEAR                       |  | 2b HOUR                                      |  |
|  |  | Maria Rosario Jiménez                                      |  |  |  | DATE ESTI. MATED  |  | 10 28 86                             |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                       |  | IF UNDER 24 HRS.                             |  |
| Female   |  | Hispanic   |  | Oct. 13, 62  |  | 24 YRS.   |  |                                      |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?                                |  | 8 MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |
| Peru   |  | Peru   |  | WIDOWED  |  | DIVORCED  |  | Baltimore City                       |  | MD.  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |                                      |  |  |  |
| Baltimore  |  | University Hospital  |  | Student  |  |   |  |                                      |  |  |  |
| 13a STATE  |  | 13b COUNTY   |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?   |  | 13e STREET ADDRESS                   |  |  |  |
| Maryland   |  | Baltimore  |  | Balto. Co.   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 108 Village of Pine Ct.              |  | 21 Apt. 1B                                   |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME                                    |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT                         |  |  |  |
| Jose Jimenez   |  | Raquel Frey  |  | No   |  | 212-92-2244   |  | Mrs. Nancy Schaffle                  |  | MD. 21133                                    |  |
|  |  |  |  |  |  |   |  | 21 Cinnamon Circle Apt. 3C           |  | Randallstown                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |                                      |  |  |  |
| IMMEDIATE CAUSE (a) Multiple injuries  |  |  |  |  |  |   |  |                                      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                      |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |  |  |  |  |   |  |                                      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                      |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |                                      |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20 AUTOPSY?  |  |   |  |                                      |  |  |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |   |  |                                      |  |  |  |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b TIME OF INJURY   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                                      |  |  |  |
|  |  | 6 P.M. 10 27 86  |  | Pedestrian struck by auto  |  |   |  |                                      |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f LOCATION   |  |   |  |                                      |  |  |  |
|  |  | street   |  | Liberty Rd at St. Michael Lane, Balto. Co, MD                                |  |   |  |                                      |  |  |  |
| 22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: |  |  |  |  |  |   |  |                                      |  |  |  |
| Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                             |  |  |  |  |  |   |  |                                      |  |  |  |
| ACTUAL SIGNATURE   |  |  |  |  |  |   |  |                                      |  | TITLE (SPECIFY)                              |  |
|  |  |  |  |  |  |   |  |                                      |  | M.D. Assistant MEDICAL EXAMINER              |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  |  |  |  |   |  |                                      |  | DATE SIGNED                                  |  |
| William M. Zane, M.D.  |  |  |  |  |  |   |  |                                      |  | 10/28/86                                     |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION  |  |                                      |  |  |  |
| Cremation  |  | 10/31/86   |  | Westview Crematory   |  | Catonsville, Baltimore, MD.   |  |                                      |  |  |  |
| 24 FUNERAL DIRECTOR  |  | 25 DATE REC'D. BY  |  | 26 OFFICE  |  |   |  |                                      |  |  |  |
| Loring Byers, Funeral Directors, Inc.  |  | OCT 31 1986  |  | Julia Denison-Randall  |  |   |  |                                      |  |  |  |
| 8728 Liberty Road  |  | Randallstown, MD. 21133                                    |  |  |  |   |  |                                      |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND RETURN IT TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST <u>SOPHIA</u> MIDDLE <u>JOFFE</u> LAST <u>JOFFE</u>                                 |  |   |  | 2a. DATE OF DEATH MONTH <u>10</u> DAY <u>16</u> YEAR <u>1986</u>              |  | 2b. HOUR <u>4:30</u> P M  |  |
| 3 SEX <u>FEMALE</u>   |  | 4 RACE <u>CAUCASIAN</u>  |  | 5. DATE OF BIRTH MONTH <u>12</u> DAY <u>10</u> YEAR <u>1907</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS.                                |  | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD                  |  |   |  |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SINAI HOSPITAL</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>TEACHER.</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>XXXXXXXXXX</u> 13c. CITY OR TOWN <u>BALTIMORE</u>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE <u>4001 CLARKS LANE #103</u> <u>21213</u>      |  |   |  |
| 14. FATHER'S NAME FIRST <u>ABRAHAM</u> MIDDLE <u>JOFFE</u> LAST <u>JOFFE</u>  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST <u>RACHAEL</u> MIDDLE <u>BLUMBERG</u> LAST <u>BLUMBERG</u>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>   |  | 16b. SOCIAL SECURITY NO. <u>214-40-2508A</u>   |  | 17 INFORMANT ADDRESS <u>BENJAMIN JOFFE</u> <u>7025 CONCORD RD. BALTO., MD 21208</u>   |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>abd distension ? ascites, nausea, anorexia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>possible @ side heart failure, old MI</u>                              |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3:40 PM</u>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> , 19 <u>86</u> , to <u>10-16</u> , 19 <u>86</u> , that (I) (we) lost the deceased alive on <u>10-16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>D Boersma</u> 2067  |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED <u>10-16-86</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D BOERSMA</u>  |  |  |  | 22e. ADDRESS <u>Sinai Hosp</u>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>   |  | 23b. DATE <u>OCT. 17, 1986</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>   |  | 23d. LOCATION CITY OR TOWN <u>BALTIMORE</u> COUNTY <u>MARYLAND</u>            |  |   |  |
| 24 FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., INC.</u> <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u>   |  |  |  | 25a. DATE REC'D BY REGISTRAR <u>OCT 23 1986</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

89 REG. NO. 28297

|   |   |   |   |   |
|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CHARLIE HERBERT JOHNSON  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 16 86   |   | 2b. HOUR<br>450 P.M.  |
| 3. SEX<br>Male  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 27 17  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Florida  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.   |
| 10. CITY OR TOWN OF DEATH<br>Balto.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Deaton Med. Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Md.   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eddie Johnson   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mattie Davis   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>257-14-7784   | 17. INFORMANT<br>Nancy Johnson  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) METASTATIC PROSTATE CANCER<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>YEARS  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 27, 1986, to Oct 16, 1986, that (I) (we) last saw the deceased alive on Oct 15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two) (did) (did not) view the body after death. |   |   |   |   |
| 22b. SIGNATURE<br>[Signature]   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>10/17/86  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KRANTZ   |   | 22e. ADDRESS<br>120 S Greene St Balto, Md   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>10-22-86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                      |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1986  |   | 25b. REGISTRAR'S SIGNATURE  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 6 2 8 2 9 8

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Dorothy Johnson</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10-27-86</i>                                  |  | 2b. HOUR<br><i>11:40 P.M.</i>  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Black</i>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>8-18-15</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>71</i> YRS.                              | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore MD</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Liberty Med Center</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MARYLAND</i>  |  |   | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>FREDERICK WOODLAND</i>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>ANNIE BOLLEN</i>                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>21842 7393</i>   |  | 17. INFORMANT ADDRESS<br><i>MR. EDWIN JOHNSON 3929 ANNELLEN RD 21215</i>       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic Pancreatic Carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>None</i>   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>10-27-86</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-27-86</i> to <i>10-27-86</i> , that (I) <del>was</del> last saw the deceased alive on <i>10-27-86</i> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Rosita R. Cruz</i>  |  | DEGREE<br><i>M.D.</i>   |  | 22c. DATE SIGNED<br><i>10-27-86</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Rosita R. Cruz</i>   |  | 22e. ADDRESS<br><i>LUTHERAN HOSPITAL</i>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPARTY)<br><i>BURIAL</i>   | 23b. DATE<br><i>11-1-86</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MD. NAT. Cem</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>F.G. Co. MD</i>               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Joseph L. Russ</i>  |  | ADDRESS<br><i>2727 W. NORTH AVE</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV - 5 1986</i>                           |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Jackson-Randall</i>                     |  |

BP

02321 NOV-70



100% COLLECTIBLE



0-21199

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

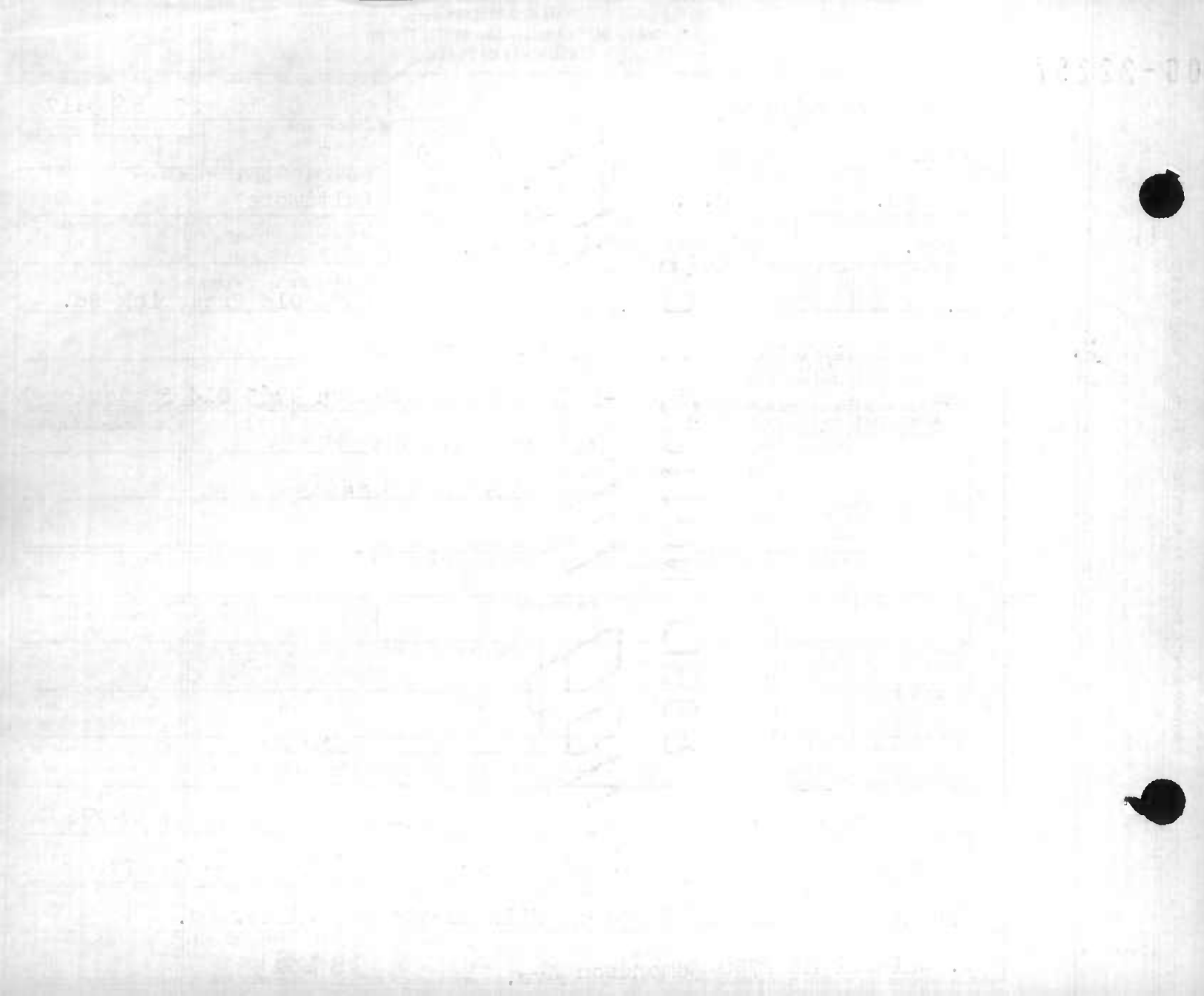
MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--------------------------------------|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 5 2 8 2 9 9  |  | REG. NO.  |  |                                      |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  | MONTH                                |  | DAY  |  | YEAR   |  | 2b. HOUR                                     |  |
| EARL S JOHNSON   |  |  |  | OCTOBER 14, 1986  |  |                                      |  |  |  |  |  | 10:00pm                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRN.   |  |  |  |
| M.   |  | NEGRO  |  | 7 6 88  |  | 78 YRS.                              |  | MONTHS   |  | DAYS   |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |  |  |  |
| WASH. D.C.   |  | U.S.A.   |  |   |  | BALTO. City MD.                      |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |                                      |  |  |  |  |  |  |  |
| BALTO.   |  | CHURCH HOSP  |  |   |  |                                      |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                      |  |  |  |  |  |  |  |
| LABORER  |  |  |  | Beth Steel  |  |                                      |  |  |  |  |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                    |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS, ZIP CODE                                  |  |  |  |
| MD   |  |  |  |   |  | BALTO                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 2228 Orleans St 21231  |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                      |  |  |  |  |  |  |  |
| Isaac JOHNSON  |  |  |  | MATTIE SIMPSON  |  |                                      |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                        |  | ADDRESS  |  |  |  |  |  |
| No   |  |  |  | 213-07-6793   |  | Pearl Johnson                        |  | 2228 Orleans St  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |                                      |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)  |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
| (c)  |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                      |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |   |  |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                      |  |  |  |  |  |  |  |
|  |  |  |  | P.M. 19   |  |                                      |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                      |  | 21f. LOCATION  |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  |   |  |                                      |  | CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>SEPTEMBER 24</u> 19 <u>86</u> , to <u>OCTOBER 14</u> 19 <u>86</u> , that (I) <u>we</u> lost <u>saw the deceased alive on</u> <u>OCTOBER 14</u> 19 <u>86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (I) <u>we</u> (do) (did not) view the body after death. |  |  |  |   |  |                                      |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  |                                      |  | 22c. DATE SIGNED   |  |  |  |  |  |
| Bernie Mappal  |  |  |  |   |  |                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |                                      |  |  |  |  |  |  |  |
| Bernie Mappal  |  |  |  | CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD. 21231  |  |                                      |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION  |  |  |  |
| Buried   |  |  |  | 10/18/86  |  | MT. CALVARY                          |  |  |  | AIA-County, Md   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25. DATE REC'D. BY REGISTRAR  |  |                                      |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| NAME ADDRESS   |  |  |  | OCT 16 1986   |  |                                      |  | John Davidson  |  |  |  |  |  |
| Locks FUNERAL HOME 1304 N. Central St  |  |  |  |   |  |                                      |  |  |  |  |  |  |  |

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1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 6 2 8 3 0 1

|  |  |   |   |   |                             |  |
|--|--|---|---|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOSEPH LEON JOHNSON</b>                        |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 24 86</b> |   | 2b. HOUR<br><b>12.50 AM</b> |  |
| 3 SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 17 1906</b>   |                             |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   | 7b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |  |
| 9. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CONTRACTOR</b>  |                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD.</b> |  | 13b. COUNTY<br><b>A.A.</b>  |   | 13c. CITY OR TOWN<br><b>GLEN BURNIE</b>   |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>THOMAS</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>FLORENCE</b>   |   | 16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                             |  | 17b. SOCIAL SECURITY NO.<br><b>705-07-7288</b>  |   | 17. INFORMANT MR. ADDRESS<br><b>MATTHEW TOWN BOX 1526 HANOVER 21076</b>   |                             |  |

|   |  |  |
|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SECURITUS ULCERS.</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> 19 <b>86</b> to <b>10/24</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>10/24</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>D. BASSIN</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/24/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BASSIN BASRO</b>   |  | 22e. ADDRESS<br><b>SOUTH BALTIMORE GENERAL HOSPITAL.</b>            |  |  |  |   |  |

|  |  |                              |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10/29/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. REST CEMETERY</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>ANNE ARUNDEL MARYLAND</b> |  |
| 24. FUNERAL HOME OR OTHER PERSON TO WHOM BODY WAS DELIVERED<br><b>NUTTER &amp; SONS FUNERAL HOME, INC.</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1986</b>            |  |   |  |
| 25b. ADDRESS<br><b>2501 GWYNNS FALLS PKWY. BALTO, MD. 21216</b>  |  |                              |  | 25c. REGISTRAR'S SIGNATURE                                     |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked for item 18 showing any injury, whether traumatic event, the medical examiner must be notified as soon as possible.

MEDICAL CERTIFICATION

1944

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CONTRACTOR BUILDING

MANUFACTURING

1944

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FOR COTTON PILES

1944

1944

0-21501

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 NO. 28302

|   |  |   |  |  |  |  |   |   |   |  |
|---|--|---|--|--|--|--|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Louise (Crawley) Johnson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 17, 1986</b>         |  | 2b. HOUR<br><b>8:25A</b> M   |  |   |   |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Black</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 11 11</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1520 Aisquith Street 21202</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Hill</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy Clark</b>    |  |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unknown</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>255-20-5644</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Barbara Lee 1520 N. Aisquith Street</b>   |  |  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic cardiovascular disease</b>  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
|   |  |   |  |  |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 15</b> 19 <b>86</b> to <b>October 17</b> 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>October 17</b> 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |   |  |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>S. Nair</b>  |  |   | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>10/17/86</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. S. NAIR, MD</b>  |  |   | 22e. ADDRESS<br><b>Solo York Road, BALTIMORE 21207</b>                 |  |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>10/23/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown, Md.</b>                          |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MARCH funeral Homes 1101 East North Avenue</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1986</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director and within 72 hours after death be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

RECEIVED NOTION 2003

DIVISIONAL





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8628303  
REG. NO.

|  |  |  |  |  |  |   |  |  |  |                  |  |           |  |          |  |
|--|--|--|--|--|--|---|--|--|--|------------------|--|-----------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OF PRINT)  |  | MIDDLE   |  | LAST   |  | 26. DATE OF DEATH   |  | MONTH  |  | DAY              |  | YEAR      |  | 26. HOUR |  |
| MARY   |  | AGNES  |  | JOHNSON  |  | 10  |  | 12   |  | 86               |  | 8.05 P.M. |  |          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS. |  |           |  |          |  |
| female   |  | white  |  | 01 15 22   |  | 64  |  | MONTHS                                       |  | DAYS             |  | HOURS     |  | MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                  |  |           |  |          |  |
| WORCHESTER MASS  |  | U.S.   |  |  |  | BALTIMORE   |  |  |  |                  |  |           |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOS. OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                  |  |           |  |          |  |
| BALTO  |  | SINAI HOSPITAL   |  | RN   |  |   |  |  |  |                  |  |           |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE               |  |                  |  |           |  |          |  |
| MD   |  | BALTO.   |  | REISTERSTOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 200 Mysticwood                               |  |                  |  |           |  | 21136    |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |                  |  |           |  |          |  |
| THOMAS   |  | ALICE  |  |  |  |   |  |  |  |                  |  |           |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                  |  |           |  |          |  |
| NO   |  | -113-30-8200   |  | PAUL JOHNSON   |  | REISTERSTOWN MD.  |  |  |  |                  |  |           |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |           |  |          |  |
|  |  | cardiac + resp'n. arrest   |  | endstage liver arthrosis   |  |   |  |  |  |                  |  |           |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |   |  |  |  |                  |  |           |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |   |  |  |  |                  |  |           |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |                  |  |           |  |          |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                  |  |           |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |  |  |                  |  |           |  |          |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                  |  |           |  |          |  |
| 22a. I certify that (this hospital) attended the deceased from 10-11-86 to 10-12-86, that (we) last saw the deceased alive on 10-12-86, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |  |  |                  |  |           |  |          |  |
| TREDUP   |  | M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 10-12-86  |  |  |  |                  |  |           |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OF PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |                  |  |           |  |          |  |
| TREDUP   |  | Sinai - Hospital   |  |  |  |   |  |  |  |                  |  |           |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |                  |  |           |  |          |  |
| BURIAL   |  | OCT 15TH   |  | ALL SAINTS CEMETRY   |  | REISTERSTOWN MD.  |  |  |  |                  |  |           |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                  |  |           |  |          |  |
| ELINE FUNERAL HOME   |  | REISTERSTOWN MD.   |  | OCT 14 1986  |  |   |  |  |  |                  |  |           |  |          |  |



THOMAS

STRATTON

ALICE

RUSSELL

PAUL JOHNSON

REGISTERED NO.

REGISTERED NO.

ALICE

STRATTON

THOMAS

PAUL JOHNSON

RUSSELL

ALICE

STRATTON

THOMAS

00-23016

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Nathaniel Johnson</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 30 86</b>   |  | 2b. HOUR<br>M<br><b>AM</b>  |  |
| 1. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 23 03</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>83</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3308 Oakfield Ave.</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Ind.</b>   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. CITY OR TOWN<br><b>Balto.</b>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>3308 Oakfield Ave.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jaramiah Johnson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-09-0390</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Louise Johnson 3308 Oakfield Ave</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE FAILURE, ISCHEMIA, DYSPROTEINEMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>CONGESTIVE FAILURE, ISCHEMIA, DYSPROTEINEMIA</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 21a. INCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/1 19 85</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2435 W. Belvedere Ave. Balto, MD</b>                    |  |
| 22. I certify that (I) (initials) attended the deceased from <b>10/25 19 86</b> to <b>10/28 19 86</b> , that (I) (we) saw the deceased alive on <b>10/25 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Monique M</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>11/3/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip E. Bronowitz MD</b>  |  | 22e. ADDRESS<br><b>2435 W. Belvedere Ave. Balto, MD</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-4-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Park</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James A. Morton &amp; Sons</b>   |  | ADDRESS<br><b>1701 Laurens St</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 - 1986</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Tidwell-Randall</b>  |  |

MEDICAL CERTIFICATION

10

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

Received of the Treasurer of the  
Board of Education the sum of  
\$100.00 for the year ending  
June 30, 1904.  
This receipt is valid only when  
countered by the Treasurer of the  
Board of Education.



Witness my hand and the seal of the  
Board of Education this 1st day of  
July, 1904.  
Superintendent of Schools

Attest:  
Treasurer of the Board of Education

00-21493

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 8 2 8 3 0 5

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SARAH JOHNSON  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 15, 1986 |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 12 03  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1518 BRADY AVENUE |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland              |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET ADDRESS / ZIP CODE<br>1518 Brady Avenue 21226  |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hinton Moore  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lisa Harris                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Unknown |  | 16b. SOCIAL SECURITY NO.<br>216-24-9678  |   | 17. INFORMANT ADDRESS<br>James Johnson 1518 Brady Avenue  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cardiac Arrest.

Louise A-S-C-V-D-

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

C.V.A.

Blindness

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/18/75, 1986, to 1-24, 1986, that (I) (we) lost saw the deceased alive on 1-24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>E.M. RAMDS M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E.M. RAMDS M.D.   |  |  |  | 22e. ADDRESS<br>4000 ANNAPOLIS RD - 21227  |  |  |  |

|  |  |                       |  |   |  |  |  |
|--|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                     |  | 23b. DATE<br>10/21/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Homes 1101 East North Avenue |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1986                |  | 25b. REGISTRAR'S SIGNATURE                                   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Pages 1 and 2 should be filed with the funeral director within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-110-00

(K)

Robert Grant  
June 11, 1952

Mr. J. Edgar Hoover

5/18/52

per [Signature]

F.C. 100 - 34 100-1000000

per [Signature]

00-21085

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6  |  |                  |  |   |  |  |  |   |  |   |  | REG. NO. 28306   |  |  |  |   |  |
|--|--|------------------|--|---|--|--|--|---|--|---|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR   |  |                  |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Shannell Johnson   |  |                  |  |   |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 6/ 16/ 19 86         |  | 2b. HOUR <input type="checkbox"/> 11:23 a.m. |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 8 85  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>7                    |  | IF UNDER 1 YR. MONTHS DAYS<br>7   |  | IF UNDER 24 HRS. HOURS MIN.<br>7                                    |  | 2c. DATE PRONOUNCED DEAD 6/ 16/ 19 86  |  | 2d. HOUR a.m.                                |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>517 E. 20th Street |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>-  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY - 13c. CITY OR TOWN Baltimore  |  |                  |  |   |  |  |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>517 E. 20th St. 21218 |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Reginald W. Johnson   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sharon Cornish |  |   |  |   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>-   |  |  |  | 17. INFORMANT ADDRESS<br>Barbara Arksdale 517 E. 20th St.   |  |   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |                  |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                  |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                  |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |
| TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |                  |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br>Gregory R. Kauffman, M.D.  |  |                  |  |   |  |  |  |   |  |   |  | DATE SIGNED<br>6/17/86   |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.   |  |                  |  |   |  |  |  |   |  |   |  | ADDRESS<br>111 Penn St.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>6/19/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery    |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Anne Arundel County, Md. |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>William C. March Funeral Hm., Inc.  |  |                  |  |   |  |  |  |   |  |   |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 15 1986 |  | 25b. REGISTRAR'S SIGNATURE<br>The Registrar |  |

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00-21905

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit, page 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 NO. 28307

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Johnson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 15 86</b>              |  | 2b. HOUR<br><b>7:13 PM</b>                                      |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 04 02</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OAKLAND, MA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>                                     | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Johnson</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ADA Johnson</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-12-5276A</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>MARY JOHNSON 927 N. FRANKLINTOWN</b>            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-24</b> , 19 <b>86</b> , to <b>10-15</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10-15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>John T Southern MD</b><br>DEGREE<br><b>John Thomas Southern</b>  |  |   |   | 22c. DATE SIGNED<br><b>10-15-86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Thomas Southern</b>  |  |   |   | 22e. ADDRESS<br><b>SINAI Hospital</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10-20-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CARVER Mem. Pk.</b>                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  | 23e. DATE RECEIVED BY REGISTRAR<br><b>OCT 21 1986</b>   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brown/Thompson F.H.</b>  |  | 24b. ADDRESS<br><b>1913 W. BALTO. ST.</b>   |   | 25b. REGISTRAR'S SIGNATURE   |   |

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0-20809

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28308  
REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | I. DECEASED NAME<br>(TYPE OR PRINT)<br>ADDIE JONES   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 9 86  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>F  |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 16 98  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Rocky Mt. N.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1005 Edmondson Ave  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>at home   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Smallwood  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara 21223   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>214-24-4595  |  |
| 17. INFORMANT<br>JAMES POLLARD RDS Box 410<br>Laraboo, PA 15450  |  | 18. CAUSE OF DEATH Enter only one cause<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive Cardiac<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Vascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>21 1986</u> to <u>10 9 1986</u> , that (I) (we) last saw the deceased alive on <u>21 1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>W G Garner   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>10/13/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WM GARNER   |  | 22e. ADDRESS<br>1139 Penna ave Bette M   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  | 23b. DATE<br>10/12/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Laraboo Plot  |  | 23d. LOCATION<br>City or Town County State<br>Laraboo, Pa.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm Smallwood 435 7910 or 84  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



00-22759

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 8 2 8 3 0 9  
REG. NO.

|   |  |  |   |   |  |  |   |  |   |   |  |
|---|--|--|---|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELDER T. JONES   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/30/86                           |   |  | 2b. HOUR<br>11:08 AM   |   |  |   |   |  |
| 3 SEX<br>male   |  | 4. RACE<br>black   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 25 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.   |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St Agnes Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Disabled   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2737 Baker Street 21215 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew Jones  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosa Price               |   |  |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-12-9466    |   | 17. INFORMANT<br>ADDRESS<br>Capt Walter Jones 2737 Baker Street                |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>   |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>15 mins.  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Multiple Organ Failure and Sepsis</u>  |  |  |   |   |  |  |   | 8 days   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Gangrenous Left Colon &amp; Peritonitis</u>  |  |  |   |   |  |  |   | 9 days   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>S/P Extended Left Hemicolectomy &amp; transverse colectomy &amp; ligation into hypogastric arteries</u>  |  |  |   |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br>10-21-86  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gangrenous Left Colon |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-21-86, 19-86, to 10-30-86, 19-86, that (I) (we) last saw the deceased alive on 10-30-86, 19-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) |  |  |   |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><u>Kenneth Crawford</u>   |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>10-30-86   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KENNETH CRAWFORD   |  |  | 22e. ADDRESS<br>900 Canton Ave. Balt MD 21229                             |   |  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>11/3/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Vet.                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills Md                                   |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1986                                   |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Anderson-Radner |  |

SECRET

SECRET



00-22109

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 3 1 0  
REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST ALMA MIDDLE RUDACILL LAST JONES   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 16 1986   |  | 2b. HOUR<br>1835P<br>M   |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 29 1904   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82<br>YRS                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGN'S HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MED. REC. LIBRARIAN         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HEALTH                                      |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN ELICOTT CITY   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2409 WESTCHESTER AVE 21043                     |
| 14. FATHER'S NAME<br>FIRST JOSEPH MIDDLE K. LAST RUDACILLE   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST HENRIETTA MIDDLE MARY LAST MARY   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO     |  |
| 16b. SOCIAL SECURITY NO.<br>212-07-0657  |   | 17. INFORMANT<br>GARY RUDACILLE   |   | 36 ADDRESS WHEEL DRIVE<br>ELICOTT CITY, MD 21043                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pancreatitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 weeks</u><br><u>one day</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>09/05/86</u> , 19 <u>86</u> , to <u>10/16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Adil Toomanchie</u> DEGREE  |   |   |   | 22c. DATE SIGNED<br><u>10/16/86</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ADIL TOOMANCHIE   |   |   |   | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |   | 23b. DATE<br>20 OCT 86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GOOD SHEPHERD CEM.                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ELICOTT CITY HOWARD MD   |   | 24. FUNERAL DIRECTOR<br>NAME SLACK FUNERAL HOME ADDRESS ELICOTT CITY, MD 21043  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1986   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Wanda P. P.</u>  |   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to the funeral director. The funeral director should be notified by the attending physician of the death of the deceased. The funeral director should be notified of the death of the deceased by the attending physician. The funeral director should be notified of the death of the deceased by the attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EST

DATE

28/1/71



10-21640

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28311  
REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BRENDA</b>  |  | 2a. DATE OF DEATH<br>MO. DAY YEAR<br><b>Oct. 10/17/86</b>   |  | 2b. HOUR<br><b>1:45 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 8, 1957</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>29</b> YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.  |  | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housekeeper</b>                         |  | 11. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>  |  |
| 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1753 East Preston Street</b>  |  | 13. CITY OR TOWN<br><b>Baltimore</b>  |  | 14. STATE<br><b>Maryland</b>   |  |
| 15. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 16. STREET ADDRESS / ZIP CODE<br><b>1753 E. Preston Street 21213</b>  |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Thelma</b>   |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 19. SOCIAL SECURITY NO.<br><b>220-64-7488</b>   |  | 20. INFORMANT<br>ADDRESS<br><b>Gary Jones 1753 E. Preston Street 21213</b>   |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Restrictive Lung Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Scleroderma</b>   |  | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>3 1/2 years</b><br><b>4 1/2 years</b> |  | 23. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |
| 24. DATE OF OPERATION<br><b>1985</b>  |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 28. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 30. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>  |  | 31. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 32. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 33. I certify that (a) (this hospital) attended the deceased from <b>March</b> 19 <b>85</b> to <b>Oct 17</b> 19 <b>86</b> , that (b) (we) last saw the deceased alive on <b>OCT 16</b> 19 <b>86</b> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did not) view the body after death. |  | 34. SIGNATURE<br><b>G. M. GACIOCH</b>   |  | 35. DATE SIGNED<br><b>10/17/86</b>   |  |
| 36. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. M. GACIOCH</b>  |  | 37. ADDRESS<br><b>Johns Hopkins Hospital</b>  |  | 38. DEGREE<br><b>MD</b>  |  |
| 39. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 40. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>  |  | 41. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Md.</b>  |  |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 43. DATE<br><b>10-22-86</b>   |  | 44. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1986</b>   |  |
| 45. FUNERAL DIRECTOR<br>NAME<br><b>Marshall W. Jones, Jr. FH 4101 Edmondson Ave.</b>  |  | 46. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  | 47. REGISTRAR'S NAME<br><b>[Signature]</b>   |  |



00-20321

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28312  
REG. NO.

|   |  |   |  |   |                      |  |  |
|---|--|---|--|---|----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Alb Jones   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-5-86 |   | 2b. HOUR<br>12:25 AM |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 25 1914   |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hosp   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Metal Finisher  |                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Eastern Plating   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Halethorpe   |                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN UNKNOWN UNKNOWN   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie A. Nelson   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>Yes  |                      | 16b. SOCIAL SECURITY NO.<br>214-18-1685  |  |
| 17. INFORMANT<br>ADDRESS<br>Joan Hall, 1913 Halethorpe Avenue, 21227  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Hepatic encephalopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>alcoholic liver disease</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Pneumonia, Chronic obstructive lung disease</u>  |  |   |  |   |                      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9/24</u> , 19 <u>86</u> , to <u>10/5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                      |  |  |
| 22b. SIGNATURE<br><u>Moonhee Lee</u>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                      | 22c. DATE SIGNED<br><u>10/5/86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Moonhee Lee</u>   |  | 22e. ADDRESS<br><u>St. Agnes Hosp. 900 Caton Ave.</u>   |  |   |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>10/8/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Olivet Cemetery   |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.   |  | ADDRESS<br>21229  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 08 1986  |                      | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

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00-21434

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHNNIE MAE JONES   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 14, 1986  |  |   | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YRS<br>9 24 27   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS  |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2030 CECIL AVENUE |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED  |   | 12b. KIND OF BUSINESS OR INDUSTRY                            |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTIMORE  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2030 Cecil Ave 21218  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN HENRE MOORE   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>FANNIE LEE LANGLEY                                |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (IF NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>220209993  |  | 17. INFORMANT ADDRESS<br>Joseph Jones 2030 Cecil Ave. 21218   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Multiple Cerebrovascular Accidents</u> |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br>-   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> 19 <u>85</u> , to <u>10/14</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Davis M. Hahn</u>  |  |  |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>10/14/86                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Davis M. Hahn  |  |  |  | 22e. ADDRESS<br>5601 Loch Raven Blvd 21239  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>10-18-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MARYLAND NATIONAL   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>LAUREL MD  |   |  |  |
| 24. FUNERAL DIRECTOR<br>March Funeral Homes 1101 EAST North Avenue  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 16 1986  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Carleen Hendell</u>   |   |  |  |

BP \_\_\_\_\_

1. The first part of the report is a summary of the work done during the period.

2. The second part is a detailed account of the work done during the period.

3. The third part is a summary of the work done during the period.

4. The fourth part is a summary of the work done during the period.

5. The fifth part is a summary of the work done during the period.

6. The sixth part is a summary of the work done during the period.

7. The seventh part is a summary of the work done during the period.

8. The eighth part is a summary of the work done during the period.

9. The ninth part is a summary of the work done during the period.

00-21825

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 3 1 4  
REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KYLE JONES</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 16 86</b>  |   | 2b. HOUR<br><b>1:15P</b> M.  |   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 8 1917</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES CON</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dairy Farmer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Agriculture</b> |
| 13a. STATE<br><b>Md.</b>  |   | 13b. COUNTY<br><b>Harford</b>   | 13c. CITY OR TOWN<br><b>Darlington</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John F. Jones</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Lou Greer</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>WW 2 218-14-9742</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Lucille Jones, 1528 Deerfield Rd., Darlington Md.</b>             |   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>- CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>- SEVERE TRIPLE VESSEL CAD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 16 86</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2003 ROCKSPRUE RD FORETHILL MD 21070</b> |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> 19 <b>86</b> to <b>10/16</b> 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/16</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                     |   |   |   |  |   |
| 22b. SIGNATURE<br><b>KARLY A. WORTH</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>10/16/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KARLY A. WORTH</b>  |   | 22e. ADDRESS<br><b>2003 ROCKSPRUE RD FORETHILL MD 21070</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>10/20/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harford Memorial Gardens</b>                            |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Aldino Harford Md.</b>   |   | 23e. DATE RECEIVED BY HOSPITAL<br><b>OCT 20 1986</b>  |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John H. Harkins</b>  |   | ADDRESS<br><b>600 Main St., Delta, Penna.</b>   |   | 25. REGISTRAR'S SIGNATURE<br><b>Julia Anderson</b>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified.

1940



0-20681

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28315  
REG. NO.

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |
|  |  | LESSIE JONES   |  |  |  | 10-06-86  |  | 11:10 A  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |  |
| MALE   |  | BLACK  |  | 8 30 24  |  | 62 YRS  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| SOUTH CAROLINA   |  | U.S.A.   |  |  |  | BALTIMORE CITY MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore  |  | BELAIR CONVALESCENTIUM   |  | UNK  |  | UNK   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE                         |  |
| MARYLAND   |  |  |  | BALTIMORE  |  |   |  | 6116 Belair Rd. 21236                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| CALVIN JONES   |  | NANCY DAVIS  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| NO   |  | 247-32-6018  |  | ELOISE JONES 1707 E. 35th ST. 21218  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)   |  | CARCINOMA OF LUNG  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  | DUE TO, OR AS A CONSEQUENCE OF WITH METASTASES   |  |  |  |   |  |  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |
|  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 09-06 1986 to 10-06 1986, that (I) (we) last saw the deceased on 10-03-86 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c. DATE SIGNED 10/6/86  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| LUIS E. RIVERA, M.D.   |  | 54 Scott Adam Road Cockeysville, Maryland 21030  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY   |  |  |  |
| BURIAL   |  | 10/11/86   |  | KING MEMORIAL PARK   |  | RANDALLSTOWN, MARYLAND  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Wm C. March  |  | 11018 N. H. Rd.  |  | OCT 10 1986  |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of this page and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified.

0-50801

RECEIVED

UNITED STATES



Library of Congress

00-22113

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH88 28316  
REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nathaniel W Jones  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 22, 1986                      |  | 2b. HOUR<br>M   |
| 3. SEX<br>Male  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 30 21  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>N.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2504 W. FAYETTE STREET |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Disabled |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Maryland  |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Jones  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Iola Horton  |  | 13d. STREET ADDRESS / ZIP CODE<br>2504 W. Fayette St. 21223                    |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214188759  |  | 17. INFORMANT<br>ADDRESS<br>Mary Jones 2504 W. Fayette Street                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from June 82 to October 86, that (I) (we) lost saw the deceased alive on October 15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><i>Barry J. Weckesser</i>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>10/23/86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barry J. Weckesser, M.D.   |   | 22e. ADDRESS<br>301 St. Paul Place Baltimore, Md 21202  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>10/27/86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md National Memorial Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel Md                        |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Homes 4300 Wabash Avenue  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1986  |  | 25b. REGISTRAR'S SIGNATURE   |   |

BP



00-22115

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28

13

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |                  |   |  |  |  |                                 |  |
|---|--|--|---|---|------------------|---|--|--|--|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nell D. Jones  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 20, 1986 |   | 2b. HOUR<br>90 M |   |  |  |  |                                 |  |
| 3. SEX<br>Female                                      |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 20, 1891   |                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                  |  | 8. IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |  |  |  |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |   |   |                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Office Worker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Waverly Press |  |                                 |  |

|  |  |  |                     |  |  |                                |  |  |   |  |  |   |  |  |
|--|--|--|---------------------|--|--|--------------------------------|--|--|---|--|--|---|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |  | 13b. COUNTY<br>City |  |  | 13c. CITY OR TOWN<br>Baltimore |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br>524 N. Charles Street 21201 |  |  |
|--|--|--|---------------------|--|--|--------------------------------|--|--|---|--|--|---|--|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Denwood A. Jones |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nellie Dennis |  |  |
|--|--|--|--|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-24-8693 |  | 17. INFORMANT<br>ADDRESS<br>Raymond A. Richards, 401 N. Charles St. 21201 |  |
|--|--|--|--|---|--|

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Complete heart block.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>A.S. C.V.D. severe</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3ma</u><br><u>10 yrs.</u> |  |  |
|--|--|--|---|--|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hemoglobin - 1hr</u> |  |  |  |  |  |
|--|--|--|--|--|--|

|                        |  |  |  |   |  |   |  |
|------------------------|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|--|--|---|--|---|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> 19 <u>83</u> to <u>10/20</u> 19 <u>86</u> , that (I) <del>met</del> <u>lost</u> saw the deceased alive on <u>10/14</u> 19 <u>86</u> , and that in my <del>own</del> <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <u>did not</u> view the body after death. |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|

|  |  |  |  |                                     |  |
|--|--|--|--|-------------------------------------|--|
| 22b. SIGNATURE<br><u>Norman R. Freeman</u>                   |  | DEGREE<br><u>DEGREE</u>                                      |  | 22c. DATE SIGNED<br><u>10/21/86</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Norman Freeman M.D. |  | 22e. ADDRESS<br>4300 N. Charles Street, Baltimore, Md. 21218 |  |                                     |  |

|   |  |                       |  |  |  |   |  |
|---|--|-----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation |  | 23b. DATE<br>10-21-86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |
|---|--|-----------------------|--|--|--|---|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1986 |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |
|--|--|--|--|--|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1100-00



00-22943

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

| FOR STATE REGISTRAR  |  |                  |  |   |  |   |  |                            |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                                      |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                       |  |  |  |  |  |  |  | REG. NO. 28319   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|------------------|--|---|--|---|--|----------------------------|--|---|--|--------------------------------------|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Robert L. Jones  |  |                  |  |   |  |   |  |                            |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>10/ 31/ 19 86                         |  |                                      |  |  |  |  |  |  |  | 2b. HOUR<br>9:05 a.m.  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 6 25 |  | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. |  | IF UNDER 1 YR. MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD 10/31/ 1986 |  |  |  |  |  |  |  |  |  | 2d. HOUR<br>9:05 a.m. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  |   |  |   |  |                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |                                      |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                       |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  |   |  |   |  |                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |                                      |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Plant Worker  |  |                       |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bakery  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>Maryland   |  |                  |  |   |  |   |  |                            |  | 13b. COUNTY<br>Baltimore  |  |                                      |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Arbutus   |  |                       |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS<br>4804 Westland Blvd. Apt B                   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Carl M. Jones   |  |                  |  |   |  |   |  |                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mabel F. Burke  |  |                                      |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |                       |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>216-22-7139  |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS<br>Mabel F. Jones 4804 Westland Blvd. Apt. B |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                  |  |   |  |   |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |   |  |                            |  |   |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  |   |  |   |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                      |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  |   |  |   |  |                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                                      |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  |   |  |   |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                      |  |  |  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |                            |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |                                      |  |  |  |  |  |  |  | DATE SIGNED<br>10/31/86  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell  |  |                  |  |   |  |   |  |                            |  | M.D. Assistant  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |  |                  |  |   |  |   |  |                            |  | ADDRESS<br>111 Penn St.   |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  |   |  |   |  |                            |  | 23b. DATE<br>11/4/86  |  |                                      |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Davis Memorial Ch. Cem.  |  |                       |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Cumberland Allegany Md.                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc.  |  |                  |  |   |  |   |  |                            |  | ADDRESS<br>4107 Wilkens Ave.  |  |                                      |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 - 1986  |  |                       |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

NO. 1000000000

DAVID M. W. WARD





00-21101

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 88 28320

|   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS JONES   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 9, 1986                 |   |   | 2b. HOUR<br>9:50p M  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 19 42   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>44 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GEORGIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MARYLAND GENERAL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?<br>MARYLAND BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |   |  |  |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>2826 Woodbrook Ave. 21218   |  |  |  |   |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter UNK Jones  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNK Drucilla Preston |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>214403218                                 |  | 17. INFORMANT<br>ADDRESS<br>MARY CROSBY 1523 Lester Morton Ct. 21205 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HEMORRHAGIC BRAIN STEM STROKE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) HYPERTENSION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>21 years   |  |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 8, 1986</u> to <u>October 9, 1986</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 9, 1986</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>Lih-jian chen   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/10/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LIH-JIAN CHEN  |  |  |  |   |   | 22e. ADDRESS<br>c/o Maryland General Hospital  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  |  | 23b. DATE<br>10-16-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. AUBURN CEM.                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MARCH F/H 1101 E. North Ave.  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 15 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>John Anderson  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



00-2077

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |                  | REG. NO. 86 28321                            |  |  |  |
|---|--|---|--|--|--|--|--|---|------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William URBAN Jones   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 9 86 |  |  |   | 2b. HOUR<br>2P M |  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEBRUARY 13, 1928  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS  |                  | 8. UNDER 24 HRS.<br>HOURS MIN.               |  |  |  |
| 9. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 10. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City                          |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                    |  | 13. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>POLISHER   |                  | 14. KIND OF BUSINESS OR INDUSTRY<br>STEEL    |  |  |  |
| 15. CITY OR TOWN OF DEATH<br>Balt.  |  | 16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City |  | 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN |  | 18. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 19. STREET ADDRESS / ZIP CODE<br>7927 EASTOALE ROAD 21224   |                  |  |  |  |  |
| 20. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WALTER V. JONES   |  | 21. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EVELYN V. MILTON   |  | 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW II   |  | 23. SOCIAL SECURITY NO.<br>228 30 9876   |  | 24. INFORMANT<br>DOROTHY LANE, 5434 S. MASTERSON #14, TUSCON, AZ 85706  |                  |  |  |  |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |  |  |  |   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |  |  |   |                  |  |  |  |  |
| 26. DATE OF OPERATION   |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |  |  |  |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                  |  |  |  |  |
| 33. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |                  |  |  |  |  |
| 36. I certify that (I) (this hospital) attended the deceased from <u>10/3</u> 19 <u>86</u> , to <u>10/9</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |   |  |  |  |  |  |   |                  |  |  |  |  |
| 37. SIGNATURE<br>Michael R. Clark MD  |  |   |  |  |  |  |  | 38. DEGREE<br>MD  |                  | 39. DATE SIGNED<br>10/9/86                   |  |  |  |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael R. Clark MD   |  |   |  |  |  |  |  | 41. ADDRESS<br>4940 Eastern Ave #14 MD 21224  |                  |  |  |  |  |
| 42. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 43. DATE<br>13 OCTOBER 86   |  | 44. NAME OF CEMETERY OR CREMATORY<br>ANGEL HILL CEMETERY   |  | 45. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HAVRE de GRACE, HARFORD CO., MD.                  |  |   |                  |  |  |  |  |
| 46. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MO. 21078   |  |   |  |  |  | 47. DATE REC'D. BY REGISTRAR<br>OCT 14 1986  |  | 48. REGISTRAR'S SIGNATURE   |                  |  |  |  |  |

00-50111



00-22408

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28322

|   |  |                         |                                    |  |  |  |  |  |                                   |   |  |
|---|--|-------------------------|------------------------------------|--|--|--|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLARENCE</b>  |  |                         | FIRST MIDDLE LAST<br><b>JORDAN</b> |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>10 25 1986</b> |  |  | 2b. HOUR<br>M<br><b>9:11 P.M.</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 4 1935</b>                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51 YRS.</b>  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                                   | 7c. DATE PRONOUNCED DEAD<br><b>10 25 1986</b> |  |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         |                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                |                                   |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |                         |                                    | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                            |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Key Medical Center</b>  |                                   |   |  |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>   |  |                         |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Southern Unif</b>                |  |  |  | 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b> |                                   |   |  |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                         |                                    | 13e. STREET ADDRESS<br><b>2027 Paulette Rd Apt. 204</b>                  |  |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence J. Jordan Sr.</b>  |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence J. Jordan Sr.</b>   |  |                         |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Evelyn Getner</b>    |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>   |                                   |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>220-30-2345</b>  |  |                         |                                    | 17. INFORMANT<br><b>Donna M. Jordan</b>                                  |  |  |  | 17. ADDRESS<br><b>Balto. MD 21222</b>  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |  |  |  |                                   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>Diabetes mellitus</b>  |  |                         |                                    |  |  |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  |                         |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                        |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |                                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)              |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |   |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |                                    |  |  |  |  |  |                                   |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  |                         |                                    | ASSISTANT MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>10-26-86</b>  |                                   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>   |  |                         |                                    | ADDRESS <b>111 Penn St., Balto., MD 21201</b>                            |  |  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |                         |                                    | 23b. DATE<br><b>10-29-86</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b>  |                                   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Middle River Balto. Maryland</b>   |  |                         |                                    | 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck Funeral Home of Dundalk</b> |  |  |  | 25. DATE REC'D. BY REGISTRAR <b>OCT 29 1986</b>  |                                   |   |  |
| 25b. REGISTRAR'S SIGNATURE  |  |                         |                                    |  |  |  |  |  |                                   |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORM NO. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 2. FORM NO. 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

00-33-00



00-22771

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 2 8 3 2 3

|  |  |   |   |  |   |  |  |   |                                    |  |
|--|--|---|---|--|---|--|--|---|------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Charles Edward Kagle</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 30 86</b>                 |  |   | 2b HOUR<br><b>1251A</b>  |  |   |                                    |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 20 13</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |                                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City.</b> MD.   |  |   |                                    |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deaton Hosp. &amp; Med. Center</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Grocery Manager</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Owner</b>  |                                    |  |
| 13a STATE<br><b>Md</b>   |  |   |   | 13b COUNTY<br><b>Balto.</b>  |   | 13c CITY OR TOWN<br><b>Balto.</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                    |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John ----- Kagle</b>   |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva May Howser</b>  |   |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                                    |  |
| 16b SOCIAL SECURITY NO.<br><b>217-32-8911</b>  |  |   |   | 17 INFORMANT<br><b>Bertha Blake (sister)</b>   |   |  |  | ADDRESS<br><b>1625 Webster St. 21230</b>  |                                    |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR ARRHYTHMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSIVE ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PERIPHERAL VASCULAR DISEASE, HEPAATIC ENCEPHALOPATHY</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |   |  |   |  |  |   |                                    |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |                                    |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                    |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>5/1</b> 19 <b>86</b> to <b>10/30</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>10/29</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |  |  |   |                                    |  |
| 22b SIGNATURE<br><b>[Signature]</b>  |  |   | DEGREE<br><b>MD</b>   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c DATE SIGNED<br><b>10/31/86</b> |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURYA P. MUNDRA</b>   |  |   | 22e ADDRESS<br><b>203 E PATAPSCO Ave Baltimore MD 21225</b>           |  |   |  |  |   |                                    |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b DATE<br><b>11/3/86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. A.A. Co. Maryland</b> |   |                                    |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home, 130 E. Fort Ave.</b>   |  |   | ADDRESS<br><b>Balto. Md. 21230</b>                                    |  |   | 25 REGISTRAR'S SIGNATURE<br><b>OCT 31 1986 [Signature]</b>   |  |   |                                    |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with this certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

BP

00-23771



Vertical text on the left margin, possibly a date or reference number, including "OCT 31 1955".

Horizontal text at the bottom of the page, including "OCT 31 1955" and other faint markings.



00-21417

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 - RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28324

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10/ 13/ 86  |  |  |  | 2b. HOUR MIN 8:35  |  |
| 1. DECEASED NAME (TYPE OR PRINT) John Frederick Kardell   |  |  |  | 3. DATE OF BIRTH MONTH DAY YEAR Sept, 11, 1953   |  |  |  | 4. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.  |  |
| 2. SEX Male   |  | 4. RACE White  |  | 5. IF UNDER 1 YR. MONTHS DAYS  |  | 6. IF UNDER 24 HRS. HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD 10/ 13/ 19 86   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION University Hospital STU |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk                                |  | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.   |  |
| 13a. STATE MD   |  |  |  | 13b. CITY OR TOWN Carroll  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13d. STREET ADDRESS 13202 Nittany Court 21791  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick Lloyd Kaedell   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola May Haslacker   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No   |  |  |  | 16b. SOCIAL SECURITY NO. 214-48-8561   |  | 17. INFORMANT ADDRESS Kensington, MD 4012 Spruell Dr.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gunshot Wound of Head<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 10/12/ 19 86   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted wound |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home   |  | 21f. LOCATION CITY OR TOWN STREET COUNTY STATE 13202 Kittany Ct. Union Bridge, Fred. Co., Md.      |  |  |  |
| 22a. I certify that I took charge of the remains described above. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE Gregory R. Kauffman, M.D.  |  |  |  | TITLE (SPECIFY) M.D. Assistant   |  |  |  | DATE SIGNED 10/14/86   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.   |  |  |  | ADDRESS 111 Penn St.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 10/16/86   |  | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR OCT 17 1986  |  | 25b. REGISTRAR'S SIGNATURE   |  |

Section

Also see, 11, 1953

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Chief

1902 Liberty Street, New York

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Union strike

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Protestants John Kennedy

Remains, NY

Way

Viola

Viola 1902 Liberty Street, New York

1902 Liberty Street, New York

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Frankwood, NY

10/11/53 To: Lincoln Jan.

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1902 Liberty Street, New York

1902 Liberty Street, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

00-22790

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DANIEL</b> <b>Kearney</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>28</b> YEAR <b>86</b>  |   |  |   |   | 2b. HOUR<br><b>10:24</b> AM   |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>3</b> YEAR <b>20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>us A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.                     |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Md</b> 13b. COUNTY <b></b> 13c. CITY OR TOWN <b>City</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>4320 Clarendon Ave 21213</b>                    |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Elmus</b> MIDDLE <b></b> LAST <b>Kearney</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b></b> LAST <b>Horton</b>  |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>198-01-374</b>   |  | 17. INFORMANT<br><b>William Kearney</b>   |  | ADDRESS <b>New Jersey 110 Charles Ave. SouthTomsRiv</b>                           |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>  |  |   |  |   |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Immediate</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF,<br>(b) <b>Chronic Renal Failure</b>  |  |   |  |   |  |   |  |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |   |  |   |  |   |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10)   |  |   |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 28</b> 19 <b>86</b> to <b>Oct 28</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>Oct 28</b> 19 <b>86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Georgina Groleau</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>10/28/86</b>   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Georgina Groleau</b>   |  |   |  |   | 22e. ADDRESS<br><b>UMH ER</b>  |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>  |  |   | 23b. DATE<br><b>10-30-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process, Inc.</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Marzullo Funeral Service</b> ADDRESS <b>Upperco, Md.</b>   |  |   |  |   | OCT 31 1986 <b>Julia Dindon-Rudner</b>   |   |  |   |   |   |  |

BP



00-555-00

00-22087

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

 DHMH - 16 60M 7/84  
 (VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 131-136<br>10-29-86 R.L.<br>per phone  |  | 8 0 2 8 3 2 6  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR P M   |  |
| BABY BOY KEENE  |  |  |  | OCTOBER 19, 1986   |  | 12:40   |  | P M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  |
| MALE  |  | BLACK  |  | MONTH DAY YEAR<br>10 19 86   |  | YRS. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| MARYLAND  |  | USA  |  |  |  | BALTIMORE CITY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13b. INSIDE CITY LIMITS?   |  | 13c. STREET ADDRESS / ZIP CODE                                      |  |  |  |
| 13a. STATE COUNTY CITY OR TOWN  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21215 5104 Litchfield Ave.  |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST  |  |   |  |  |  |
| LEWIS BROWN   |  |  |  | CATHERINE KEENE  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |
|   |  |  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>   |  |  |  |  |  |   |  | 5 MINUTES  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary insufficiency</u>   |  |  |  |  |  |   |  | 4 1/2 HRS  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Extreme prematurity</u>   |  |  |  |  |  |   |  | 4 1/2 HRS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |   |  |  |  |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10/19</u> , 19 <u>86</u> , to <u>10/19</u> , 19 <u>86</u> , that (1) (we) lost <u>10/19</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| <u>John J. McCloskey, M.D.</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 10/19/86  |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| John McCloskey MD.  |  | JHH, 600 N. Wolfe St., -Baltimore Md. 21205  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |
| CREMATION   |  | 10-19-86   |  | JOHNS HOPKINS HOSP   |  | 601 no. Wolfe st. BALTIMORE MD. 21205                               |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| NAME  |  |  |  | OCT 27 1986  |  | Julia Swanson-Lusher  |  |  |  |
| ADDRESS   |  |  |  |  |  |   |  |  |  |



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00-22541

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 3 2 1  
REG. NO.

|   |  |  |   |  |                                     |   |  |
|---|--|--|---|--|-------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CAROLINE KEIGLER</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 9 86</b> |  | 2b. HOUR<br><b>6:45<sup>P</sup></b> |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 25 89</b>   |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HRS. MIN.<br><b>97</b>                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Roland Park Health Care</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fitter</b>   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William J. Keigler</b>                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Heer</b>  |   | 16. ADDRESS<br><b>830 W. 40th St.</b>  |                                     | 17. INFORMANT<br><b>Ms. Dorothy Keigler Balto., Md.</b>   |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>      |  | 18b. SOCIAL SECURITY NO.<br><b>215-05-9323</b>   |   | 18c. DATE OF DEATH<br><b>10-9-86</b>   |                                     | 18d. DATE OF BIRTH<br><b>6-25-89</b>  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cong 1 Heart Failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 Months</b> |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/10/89</b> to <b>10/15/86</b> , that (I) (we) last saw the deceased alive on <b>10/9/86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>R. Diamond</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>10-16-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD L DIAMOND</b>   |  |  |  | 22e. ADDRESS   |  |  |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b> |  | 23b. DATE<br><b>10-9-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>        |  |                             |  | 25. DATE REC'D BY REGISTRAR<br><b>OCT 27 1986</b> |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>       |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's office must be notified.

10-11-1963  
FBI  
WASH DC

3/5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed by a licensed physician.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GEORGE W. KELLER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 12, 1986   |  | 2b. HOUR<br>10:4 A.M.  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 26, 1917   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Ohio  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6101 Loch Raven Blvd. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Director of Blind Services  | 12b. KIND OF BUSINESS OR INDUSTRY<br>St. of MD 21239                                 |  |
| 13a. STATE<br>MD  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Reamer Keller   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Hosey   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>218 36 8017   | 17. INFORMANT<br>ADDRESS<br>Virginia M. Keller, Same  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary By-Pass Surg. 1 yr.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes</u><br><u>2 yrs</u><br><u>1 yr.</u> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3/27</u> , 19 <u>59</u> , to <u>10/12</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>William P. Benson</u>  |  | DEGREE<br><u>M.D.</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>10/13/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William P. Benson, MD  |  | 22e. ADDRESS<br>3506 N. Calvert St., Balto., MD   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>10/14/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. County MD                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 15 1986  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |
| 4905 York Road Balto., MD   |  | 21212   |   |  |  |

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10. The following information is available for the year ended 31/12/2012:

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-22968

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8028327

1- FOR  
STATE  
REGISTRAR

|  |                                     |   |   |  |   |
|--|-------------------------------------|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Veneta V Keller  |                                     |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-29-86                   |  | 2b. HOUR<br>12:00 M   |
| 3. SEX<br>Female   | 4. RACE<br>Cauc.                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-26-1897  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 yrs.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3522 Erdman Avenue                             |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Telephone Op.    | 12b. KIND OF BUSINESS OR INDUSTRY<br>C & P  |
| 13a. STATE<br>Md.  |                                     | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Balto.                                       | 13d. STREET ADDRESS / ZIP CODE<br>3522 Erdman Avenue 21213                           |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Peter Fallon   |                                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Conroy |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-07-0669  |   | 17. INFORMANT<br>ADDRESS<br>21214<br>Carolyn Nuth 4211 Harcourt Road                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Probable Cardiac arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Generalized atherosclerotic vascular disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |                                     |   |   |  |   |
| 19a. DATE OF OPERATION   |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-26</u> , 19 <u>86</u> , to <u>10-29</u> , 19 <u>86</u> , that (I) <del>was</del> lost<br>saw the deceased alive on <u>6-16</u> , 19 <u>86</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>did not</del> did not view the body after death.  |                                     |   |   |  |   |
| 22b. SIGNATURE<br><u>Carla Wolf Rosenthal</u>  |                                     | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   |  | 22c. DATE SIGNED<br>10-30-86  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Carla Wolf Rosenthal, M.D.</u>   |                                     | 22e. ADDRESS<br><u>3400 Brehms Lane, Baltimore MD 21213</u>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11-3-86                | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                            |   |
| 24. FUNERAL DIRECTOR<br><u>Schimmunek Funeral Home, Inc.</u><br><u>3331 Brehms Lane, Balto., Md. 21213</u>   |                                     | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1986   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Anderson</u>                                  |   |

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WINTER

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10-2-01

00-20296

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 8 3 3 0

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE — KERBEL</b>  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>10-05-86</b>                              |   | 2b HOUR<br><b>6:15 A.M.</b>  |
| 3 SEX<br><b>MALE</b>   | 4 RACE<br><b>CAUCASIAN</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>5 1902 12-07-87</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83 YRS.</b>                                |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>XX XX</b>   |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE NURSING HOME</b> |  | 12a EMPLOYED<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF EMPLOYED</b> |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>GROCERY STORE</b>   |
| 13a STATE<br><b>MARYLAND</b>   |   |  | 13b COUNTY  | 13c CITY OR TOWN<br><b>BALTIMORE</b>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX — KERBEL</b>   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>DORA — UNKNOWN</b>                |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b SOCIAL SECURITY NO.<br><b>219-16-76754</b>   |   | 17 INFORMANT<br>ADDRESS<br><b>MRS. ROSE KERBEL 4013 W. ROGERS AVE. 21215</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Urinary tract infection</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 wk.</b>  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 wks</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>  |   |  |   |   |  |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>10/5 1986</b> to <b>10/5 1986</b> , that (I) (we) last saw the deceased on <b>10/5 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |   |  |   |   |  |
| 22b SIGNATURE<br><b>Levenson</b>   |   | DEGREE<br><b>MD</b>  |   | 22c DATE SIGNED<br><b>10/5/86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. S. LEVENSON</b>   |   | 22e ADDRESS<br><b>LEVINDALE</b>  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b DATE<br><b>10/6/86</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MENS CEM</b>  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>                  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>06108 1986</b>                               |   | 25b REGISTRAR'S SIGNATURE  |
| 6010 REISTERSTOWN RD. BALTO, MD 21215  |   |  |   |   |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the funeral director. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be marked at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 88 28331   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>EARL FRANCIS KIDWELL   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 17 86  |  | 2b. HOUR<br>4:30 P.M.  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>01 01 18   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital                                |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Shop Manager                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>A.A. County   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD   |  | 13b. COUNTY<br>A.A.   |  | 13c. CITY OR TOWN<br>Glen Burnie  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1001 Sunnybrook Dr. 21061  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Oscar Kidwell   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Edna Duvall   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW 2  |  | 17. INFORMANT<br>220-36-9872  |  | ADDRESS<br>Blanche Kidwell same as 13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute GI bleeding</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Transitional Cell Ca of Bladder</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days<br>years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>DIABETES MELLITUS</u>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 86</u> to <u>Oct 17 86</u> , that (I) (we) last saw the deceased alive on <u>Oct 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) (on) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Paul E. Gormley</u>   |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>10/17/86  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL E. GORMLEY   |  | 22e. ADDRESS<br>900 CATON AVE   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>20 Oct. 86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. MD                                  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>James S. Kirkley Glen Burnie MD 21061   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1986  |  |  |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |





00-20366

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the certificate and return it to the funeral director. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 3 3 2  
REG. NO.

|  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>POK KIM</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 7, 1986</b> |   |  | 2b. HOUR<br><b>2:50 A</b>   |  |   |  |
| 3. SEX<br><b>7</b>   |  | 4. RACE<br><b>Korean</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 27 27</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Korea</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Korea</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Balto</b>  |   | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>103 E 21st St.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sang Duk</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pok Choi</b>   |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY #<br>(IF YES, GIVE WAR OR DATES)<br><b>444-78-7700</b>  |   | 17. INFORMANT ADDRESS<br><b>Yong Hean 103 E 21st St.</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Disseminated Intravascular Coagulation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Non infectious Hepatitis</b>   |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>36 hours</b><br><b>Five weeks</b>                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>10/6/86</b> , 19 <b>86</b> , to <b>10/7</b> , 19 <b>86</b> , that (1) (we) lost<br>saw the deceased alive on <b>10/7</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Patrick C. Malloy MD</b>  |  |  |   | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>10/7/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Patrick C. Malloy MD</b>   |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore, MD</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>10-9-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md</b>                                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Norm D. Carroll</b>   |  |  |   | ADDRESS<br><b>1712 W. No. Ave</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 08 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John D. ...</b>  |  |

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00-21070

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL-OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copy and return it to the funeral director. Page 3 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |  | 2c. MIN.                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | RHEA RUTH KIMMELMAN  |  | OCTOBER 10, 1986   |  | 5:58 AM  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR                           |  |
| FEMALE  |  | WHITE  |  | OCT. 28, 1913  |  | 72   |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |  |
| GEORGIA   |  | USA  |  |  |  | BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  | HOUSEWIFE  |  | AT HOME  |  |  |  |
| 13a. STATE  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS / ZIP CODE                                 |  |  |  |
| MARYLAND  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 4012 CARTHAGE RD. #21133                                       |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT                                |  |
| JACOB   |  | ESSIE  |  | NO   |  | 217-56-8469  |  | HERMAN KIMMELMAN                             |  |
|   |  |  |  |  |  |  |  | 4012 CARTHAGE RD. RANDALLSTOWN, MD 21133     |  |
|   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  |  |  |  |  |  |  | 30 min                                       |  |
|   |  |  |  |  |  |  |  | 4 days                                       |  |
|   |  |  |  |  |  |  |  | 71 years                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9.2.86 to 10.10.86, that (I) (we) lost the deceased alive on 10.10.86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | MEDICAL ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED   |  |  |  |
|   |  | MD   |  |  |  | 10.10.86   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 600 N. WOLFE ST.   |  |  |  |  |  |
| CHARLTON A. WILSON MD.  |  | JOHNS HOPKINS HOSPITAL   |  | BALTO. MD 21205  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |  |
| BURIAL  |  | OCT. 10, 1986  |  | MIKRO KODESH-BETH ISRAEL   |  | BALTIMORE MARYLAND   |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| SOL LEVINSON & BROS., INC.  |  | OCT 14 1986  |  |  |  |  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO. MD   |  | 21215  |  |  |  |  |  |  |  |

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023289 NOV-78

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR 1- STATE REGISTRAR 2/10/87   |  |              |  |                            |   |                              |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                            |  |   |   |  |  |  |  | REG. NO. 28334 |  |
|--|--|--------------|--|----------------------------|---|------------------------------|--|--|--|---|--|----------------------------|--|---|---|--|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Arthur Kinlaw  |  |              |  |                            | 2a. DATE KNOWN OF DEATH<br>10 28 19 86  |                              |  |  |  | 2b. HOUR<br>6:27 A.M.   |  |                            |  |   |   |  |  |  |  |                |  |
| 3. SEX<br>Male   |  | 4. RACE<br>C |  | 5. DATE OF BIRTH<br>1-7-29 |   | 6. AGE (IN YEARS)<br>57 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>10 28 19 86   |  |                            |  |   | 2d. HOUR<br>6:27 A.M.   |  |  |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  |              |  |                            | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                              |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                            |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |              |  |                            | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1700 Blk. 29th Street |                              |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>COUNSELLOR   |  |                            |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>REHAB  |  |  |  |  |                |  |
| 13a. STATE<br>Maryland   |  |              |  |                            |   |                              |  |  |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTO |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>1700 E. 29 St 21218 |  |  |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew Kinlaw  |  |              |  |                            |   |                              |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Verniceella Jones  |  |                            |  |   |   |  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |              |  |                            | 16b. SOCIAL SECURITY NO.<br>119 22 9689   |                              |  |  |  | 17. INFORMANT ADDRESS<br>Mrs Dorothy Kinlaw 1700 E. 29 St 21218   |  |                            |  |   |   |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |              |  |                            |   |                              |  |  |  |   |  |                            |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Arteriosclerotic cardiovascular disease.</u>   |  |              |  |                            |   |                              |  |  |  |   |  |                            |  |   |   |  |  |  |  |                |  |
| 19a. DATE OF OPERATION   |  |              |  |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                              |  |  |  |   |  |                            |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |              |  |                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10 28 1986  |                              |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Subject used drugs   |  |                            |  |   |   |  |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |              |  |                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>unknown  |                              |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>unknown  |  |                            |  |   |   |  |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |              |  |                            |   |                              |  |  |  |   |  |                            |  |   |   |  |  |  |  |                |  |
| ACTUAL SIGNATURE<br><i>William M. Zane</i>   |  |              |  |                            | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |                              |  |  |  |   |  |                            |  |   | DATE SIGNED<br>10/28/86   |  |  |  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>William M. Zane, M.D.   |  |              |  |                            | ADDRESS<br>111 Penn St. Balto.M.D   |                              |  |  |  |   |  |                            |  |   |   |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>Burial   |  |              |  |                            | 23b. DATE<br>11-1-86  |                              |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO CAM   |  |                            |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD                          |  |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Rugg   |  |              |  |                            | ADDRESS<br>2227 W. North Ave  |                              |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV - 5 1986   |  |                            |  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                |  |  |  |  |                |  |

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28335  
REG. NO.

|   |  |   |                     |   |                   |  |                    |  |                   |   |
|---|--|---|---------------------|---|-------------------|--|--------------------|--|-------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><b>Girther</b>   | MIDDLE<br><b>C.</b> | LAST<br><b>King</b>   | 2a. DATE OF DEATH |  | MONTH<br><b>10</b> | DAY<br><b>8</b>  | YEAR<br><b>86</b> | 2b. HOUR<br><b>1:10 P.M.</b>  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |                     | 5. DATE OF BIRTH<br><b>2-7-47</b>   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> 72 YRS.                                 |                    | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |                   | IF UNDER 24 HRS<br>HOURS<br>MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Louisiana</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, MD</b>                         |                    |  |                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General</b> |                     |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Teaching</b>   |                   |   |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Louisiana</b>  |  | 13b. CITY OR TOWN<br><b>Allen</b>   |                     | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   | 13d. STREET ADDRESS / ZIP CODE<br><b>1104 Oliver St. 71463</b>                       |                    |  |                   |   |
| 14. DECEASED'S NAME<br>FIRST<br><b>Iseac</b>  |  | MIDDLE<br><b>Caldwell</b>   |                     | LAST<br><b>Emme</b>   |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Emme</b>                                     |                    | MIDDLE<br><b>Hankins</b>   |                   | LAST<br><b>Hankins</b>  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>465462914</b>   |                     | 17. INFORMANT<br><b>Dorothy Spears</b> ADDRESS<br><b>Odenton, Maryland 21113</b><br><b>1357 Rosanna Dr.</b>   |                   |  |                    |  |                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic renal failure</b><br>diabetes  |  |   |                     |   |                   |  |                    |  |                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>4 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |                     |   |                   |  |                    |  |                   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                     |   |                   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                   |  |                    |  |                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                     | 21f. LOCATION<br>STREET   |                   | CITY OR TOWN   |                    | COUNTY   |                   | STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> 19 <b>86</b> , to <b>10/18</b> 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/18</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |                     |   |                   |  |                    |  |                   |   |
| 22b. SIGNATURE<br><b>Kevin Doyle</b>  |  | DEGREE<br><b>MD</b>   |                     | 22c. DATE SIGNED<br><b>10/18/86</b>   |                   |  |                    | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kevin Doyle</b>  |                   |   |
| 22e. ADDRESS<br><b>615 Hammonds La. Bkto. MD 21225</b>  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |                     | 23b. DATE<br><b>10/14/86</b>  |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Community Cemetery</b>                      |                    | 23d. LOCATION<br>CITY OR TOWN<br><b>Oakdale</b>  |                   | STATE<br><b>Allen</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond C. Fink</b>  |  | GLEN BURNIE, MD 21061   |                     | 25a. DATE RECD. BY REGISTRAR<br><b>OCT 19 1986</b>  |                   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |                    |  |                   |   |

MEDICAL CERTIFICATION

-20403

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked question 18 shows any injury, or other traumatic event, the medical certificate must be signed by a physician.

BP

DHMH: 16 60M 7/84  
(VRA 15, 4)

ENDS

85551 *Engraulis mordax* Richardson

31

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1000



00-22123

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and return them to the funeral director. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 6 2 8 3 3 0   |   |
|---|--|--|--|---|---|
| 1- FOR STATE REGISTRAR Rachel Marie Kirkpatrick   |  |  |  | CERTIFICATE OF DEATH  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT) Rachel Kirkpatrick   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR 10-24-86                            |   | 2b HOUR<br>140 AM                       |
| 3 SEX<br>FEMALE   | 4 RACE<br>WHITE  | 5 DATE OF BIRTH<br>MONTH DAY YEAR 9 23 86  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>31 DAYS YRS 0 31                            |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO, MD   | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                      |   |
| 10 CITY OR TOWN OF DEATH<br>BALTO   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>--- |   | 12b KIND OF BUSINESS OR INDUSTRY<br>--- |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE 13b COUNTY 13c CITY OR TOWN<br>Maryland Baltimore Essex  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e STREET ADDRESS / ZIP CODE<br>654 Middlesex Road 21221                     |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Lee Garganis  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kathleen Moria Kirkpatrick   |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b SOCIAL SECURITY NO.<br>---   |  | 17 INFORMANT ADDRESS<br>Kathleen M. Kirkpatrick (same)                        |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPTIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF (c) OVERWHELMING SEPSIS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12-24 hours |  |  |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>PREMATURITY   |  |  |  |   |   |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a I certify that (I) (this hospital) attended the deceased from 9-23 1986, to 10-24 1986, that (II) (we) lost saw the deceased alive on 10-24 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death.   |  |  |  |   |   |
| 22b SIGNATURE<br>E. CARTAYA MD  |  |  |  | 22c DATE SIGNED<br>10-24-86   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. CARTAYA  |  |  |  | 22e ADDRESS<br>4940 EASTERN AV BALTO MD                                       |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b DATE<br>10/25/86   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.                    |   |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County Maryland  |  | 23e DATE REC'D. BY REGISTRAR 23f REGISTRAR'S SIGNATURE<br>OCT 24 1986  |  |   |   |
| 24 FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave.  |  |  |  |   |   |

BP

Robert Marie Kirkpatrick

Baltimore City

Francis Scott Key Medical Center

Baltimore Essex x x 21221

Robert Lee Garganis Kathleen Marie Kirkpatrick

NO -- -- Kathleen L. Kirkpatrick (same)

10/25/66 Gardens of Faith Cem. Baltimore County Maryland

Funeral Home P.O. Box 100 Old Eastern Ave.

00-22611

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 NO. 28337

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Marcell Kiser</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-29-86</b>   |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Fe</b>   |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5-13-37</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>49</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3427 Payton Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Employed</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Marcell Allen</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Laurie Pencil</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3427 Payton Ave. 21215</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>216 34 1333</b>   |  | 17. INFORMANT<br><b>James E. Kiser 3427 Payton Ave.</b>   |  | 17. ADDRESS<br><b>21215</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-VASCULAR ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHROMOZOMAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CEREBRO VASCULAR ACCIDENT</b> |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>10-28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 27b. SIGNATURE<br><i>Emilio Ramos, M.D.</i>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 27c. DATE SIGNED<br><b>10-29-86.</b>   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EMILIO RAMOS, M.D.</b>  |  | 27e. ADDRESS<br><b>U. OF MD HOSPITAL BALTO 21201.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-1-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nas. A. Morton &amp; Sons</b><br>ADDRESS<br><b>1701 Laurens St.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 30 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain in the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

72227

00-32611

10-18-88

State

County

To

10-27

U.S.A. 17  
3437 1701 Avenue  
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1701 Avenue

00-21723

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28338

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |                      |  |  |  |                                       |  |  |
|--|--|--|--|---|----------------------|--|--|--|---------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><b>FRANCES</b>  |  | MIDDLE<br><b>L.</b>   | LAST<br><b>KLINE</b> |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 21 86</b> |  | 2b. HOUR<br><b>12:30p<sub>M</sub></b> |  |  |
| 1. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-18-1887</b>   |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                                       | 7b. IF UNDER 24 HRS<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                  |  |  |                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BELAIR CONVALESCENTIUM</b> |  |   |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Seamstress/Manager</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                       |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3312 Gibbons Ave. 21214</b>   |                                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Lewis</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Keogh</b>   |                      |  |  |  |                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-01-8179 A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Dennis Kline, 1918 Haver Hill Rd. 21234</b>  |                      |  |  |  |                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO SCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>ARTERIO SCLEROSIS</b> |  |  |  |   |                      |  |  |  |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>DEMENTIA.</b>   |  |  |  |   |                      |  |  |  |                                       |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                      |  |  |  |                                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |  |  |  |                                       |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>7-15</b> , 19 <b>83</b> , to <b>10-21</b> , 19 <b>86</b> , that (1) (we) last saw the deceased on <b>10-21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) saw the body after death.      |  |  |  |   |                      |  |  |  |                                       |  |  |
| 22b. SIGNATURE<br><b>RIVERA</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                      |  |  | 22c. DATE SIGNED<br><b>10/21/86</b>  |                                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RIVERA</b>   |  |  |  | 22e. ADDRESS  |                      |  |  |  |                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10-24-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                   |  |  |                                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>   |  |  |  |   |                      | 25a. DATE RECEIVED BY REGISTRAR<br><b>10/22/86</b>   |  | 25b. REGISTRAR'S SIGNATURE   |                                       |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Actual

10/1

10/1

Amount

10/1

RECEIVED

10/1



10/1

10/1

10/1

10/1

10/1

10/1

10/1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 REG. NO. 2 8 3 3 9

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOESPH KLEIN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 / 08 / 86</b> |  |  | 2b. HOUR<br><b>6:26 AM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 / 17 / 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>HUNGARY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OPERATOR</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TIE MANUFACT.</b>  |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6620 EBERLE DR. APT. 201 #21215</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>YITCHAK KLEIN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PEARL UNKNOWN</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-2326</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. ESTHER KLEIN APT. 201</b><br><b>6620 EBERLE DR. BALTO., MD 21215</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>NON HODGKIN'S LYMPHOMA, COPD/PNEUMONITS</b><br>DUE TO, OR AS A CONSEQUENCE OF } (c) <b>BONE MARROW SUP: THROMBOCYTOPENIA, ANEMIA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>8 TOBACCO USAGE, COPD, DECUBITUS</b>   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard J. Segal</b>   |  |   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>10/8/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD J. SEGAL</b>  |  |   |  | 22e. ADDRESS<br><b>SINAI HOSP OF BALT.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>OCT. 9, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

BP



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0-20698

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 28340

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Geraldine D. KLIMA</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 8, 1986</b>   |  | 2b. HOUR<br><b>7:40 A</b>  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-10-1919</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CASHIER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STORE</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERBERT DEACON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LORETTA BRIGHT</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-12-3645</b>   |  |
| 17. INFORMANT<br>NAME ADDRESS<br><b>Mr. Walter J. Klima - 831 N. Madeira St. 21205</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest, secondary to arteriosclerotic cardiovascular disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis; pneumonia; chronic renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Upper gastro-intestinal bleed</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>September 8, 1986</b> , to <b>October 8, 1986</b> , that (we) last saw the deceased alive on <b>October 8, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>LA RONDELLE</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10-11-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MATTHEWS</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John J. Hill - 2334 Jefferson St.</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>OCT 10 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

MEDICAL CERTIFICATION

3305-0

DATE: 10/10/50  
TIME: 10:10 AM



TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible due to fading and bleed-through from the reverse side of the page. It appears to be a multi-paragraph memorandum or letter.]

00-22455

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the page from the book and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 8 2 8 3 4 1  
REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDWARD Leslie KLINGEL Sr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 24 86</b> |   |  | 2b. HOUR<br><b>12 04 P.M.</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 31 26</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP OF BALT.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plumber</b>              |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>   |  |   |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALT</b>  |  | 13c. CITY OR TOWN<br><b>BALT</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Daniel Klingel Sr.</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><b>Lottie Wheeler</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF KNOWN)<br><b>212 22 1744</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>(WIFE) MARY KLINGEL 5704 CUTHBERT AVE. 21215</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>12 CHEMIC CARDIOMYOPATHY.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)<br><b>HEPATIC FAILURE, ACUTE TUBULAR NECROSIS, VENT ARRHYTHMIA, COPD</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MD</b>   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/22</b> , 19 <b>86</b> , to <b>10/24</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/24</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                      |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>VORPERIAN</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10-24-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VORPERIAN, VICKEN</b>  |  |   |  | 22e. ADDRESS<br><b>SINAI HOSP OF BALT</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10-27-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Prk Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee-Henss Funeral Home 3631 Falls Rd 21211</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |

OCT 29 1986

00-32122

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28342

|  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
|--|---------|------------------------------|--|---|--|--|--|---|--|--------------------------------------|--|---|--|--|--|--|--|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST                        |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN OF DEATH   |  |                                      |  | 2b. HOUR  |  |  |  |  |  |                       |  |
| Walter   |         |                              |  |   |  | Kluczyk  |  | MONTH DAY YEAR<br>10 18 86  |  |                                      |  | 10 18 86  |  |  |  |  |  |                       |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD             |  |   |  | 7d. HOUR                                     |  |  |  |                       |  |
| Male   | White   | 6 6 05 81 YRS.               |  | 05 81 YRS.  |  |  |  |   |  | MONTH DAY YEAR<br>10 21 86           |  |   |  | 10:36 a.m.                                   |  |  |  |                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |  |  |  |  |                       |  |
|  |         | U.S.                         |  |   |  |  |  |   |  | Baltimore City, MD.                  |  |   |  |  |  |  |  |                       |  |
| 10. CITY OR TOWN OF DEATH  |         |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |                       |  |
| Baltimore  |         |                              |  | 227 S. Broadway   |  |  |  | (Soc. Security)   |  |                                      |  |   |  |  |  |  |  |                       |  |
| 13a. STATE   |         |                              |  |   |  |  |  |   |  |                                      |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                            |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS   |  |
| Md.  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  | Balto.                                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 227 S. Broadway 21231 |  |
| 14. FATHER'S NAME  |         |                              |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| FIRST MIDDLE LAST  |         |                              |  |   |  | FIRST MIDDLE LAST  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         |                              |  | 16b. SOCIAL SECURITY NO.                                    |  |  |  | 17. INFORMANT ADDRESS   |  |                                      |  |   |  |  |  |  |  |                       |  |
| (YES, NO, OR UNKNOWN)  |         |                              |  | (IF YES, GIVE WAR OR DATES)                                 |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| Unkn.  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |                       |  |
| PART I DEATH WAS CAUSED BY:  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| (c)  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| 19a. DATE OF OPERATION   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |   |  |                                      |  | 20. AUTOPSY?  |  |  |  |  |  |                       |  |
|  |         |                              |  |   |  |  |  |   |  |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                              |  | 21b. TIME OF INJURY   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                      |  |   |  |  |  |  |  |                       |  |
|  |         |                              |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |         |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |  | 21f. LOCATION   |  |                                      |  |   |  |  |  |  |  |                       |  |
|  |         |                              |  |   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |                                      |  |   |  |  |  |  |  |                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |
| ACTUAL SIGNATURE   |         |                              |  | M.D. Assistant  |  |  |  | MEDICAL EXAMINER  |  |                                      |  | DATE SIGNED 10/21/86  |  |  |  |  |  |                       |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                              |  | William M. Zane, M.D.                                       |  |  |  | ADDRESS   |  |                                      |  | 111 Penn St. Balto.MD.  |  |  |  |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                              |  | 23b. DATE   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                      |  | 23d. LOCATION   |  |  |  |  |  |                       |  |
| Removal  |         |                              |  | 10-29-86  |  |  |  |   |  |                                      |  | CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                       |  |
| 24. FUNERAL DIRECTOR   |         |                              |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                      |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE                               |  |                       |  |
| NAME ADDRESS   |         |                              |  |   |  |  |  | NOV 05 1986   |  |                                      |  |   |  |  |  | John Davidson-Randall                                    |  |                       |  |
| Anatomy Board Balto., Md.  |         |                              |  |   |  |  |  |   |  |                                      |  |   |  |  |  |  |  |                       |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0-22970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|  |  |  |  |   |  |  |  |  |               |   |  |  |  |
|--|--|--|--|---|--|--|--|--|---------------|---|--|--|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |               |   |  |  |  |
| REG. NO. 86 28343  |  |  |  |   |  |  |  |  |               |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CLIFFORD L. KNIGHT  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 31, 1986   |  |  | 2b. HOUR<br>M |   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>January 26, 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>90   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |               |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                    |  |  |               |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3141 Dudley Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Sec./Treas.                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Title Gaurentee   |               |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3141 Dudley Ave. 21213   |               |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |               |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>WW1 216-09-1440A  |  | 17. INFORMANT ADDRESS<br>D.Hawthorne 5716 Utrecht Ave. 21206                                 |  |  |               |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |               |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |  |  |  |   |  |  |  |  |               |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)   |               |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |               |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |               |   |  |  |  |
| 22b. SIGNATURE<br>Kemper Owens   |  |  |  | DEGREE<br>MD  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |               | 22c. DATE SIGNED<br>10/31/86  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kemper Owens  |  |  |  | 22e. ADDRESS<br>Md. General Hospital  |  |  |  |  |               |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>11-3-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National                                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Maryland  |               |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home   |  |  |  |   |  | 24b. DATE REC'D. BY REGISTRAR<br>NOV-5-1986  |  | 24c. REGISTRAR'S SIGNATURE<br>Julia Gordon-Radaer  |               |   |  |  |  |







00-22718

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after a traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28344

|   |  |  |  |   |  |  |   |  |   |  |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>REV. EDNA F. KNIGHT  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 29, 1986                |   |  | 2b. HOUR<br>M  |   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 5 10  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                          |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>813 BEAUMONT AVENUE |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A              |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>813 Beaumont Avenue 21212 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John T. Frazier   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Brown            |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>215-01-8925                                |   | 17. INFORMANT<br>ADDRESS<br>George Knight 813 Beaumont Avenue                  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Infected Skin Ulcer</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>Acute Monocytic Leukemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>2 months</u><br><u>7 months</u> |  |  |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1986</u> to <u>Oct 17, 1986</u> , that (I) (we) lost saw the deceased alive on <u>10/17</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |   |  |
| 22a. SIGNATURE<br><u>Terry L. Spivak</u>  |  |  |  |   | DEGREE   |  | 22c. DATE SIGNED<br><u>10/30/86</u>   |  |   |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Terry L. Spivak MD</u>  |  |  |  |   | 22e. ADDRESS<br><u>Johannes Hopkins Hospital</u>                               |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>11/3/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Homes 1101 East North Avenue  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1986                                   |  |   |  |   |  |



00-20914

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 2 8 3 4 5

FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |  |  |  |  |  |  |                                |                                   |   |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--------------------------------|-----------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>(Esther)<br>Ester   |  |  | FIRST<br>J.  |  |  | MIDDLE<br>K.  |  |  | LAST<br>Knight   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/11/86                  |  |                                | 2b. HOUR<br>M                     |   |  |   |  |  |  |
| 3. SEX<br>female   |  |  | 4. RACE<br>Black   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 29 04   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS                  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                        |  |                                | IF UNDER 24 HRS.                  |   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE City MD. |  |  |  |  |                                |                                   |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2236 Foxbane Square |  |  |   |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |  |  |  |  |   |  |  |  |  |  | 13b. COUNTY<br>City  |  | 13c. CITY OR TOWN<br>Baltimore |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2236 Foxbane Square 21209 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry J.   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |  |  |  |                                |                                   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>225-68-0878   |  |  |  |  |  | 17. INFORMANT<br>ADDRESS<br>Ronald Jones 2236 Foxbane Square     |  |                                |                                   |   |  |   |  |  |  |

|  |  |  |  |   |  |  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acidosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>diabetes mellitus</u>   |  |  |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 months<br>9 months<br>12 years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>Coronary Heart failure, sacral decubitus ulcers.</u>  |  |  |  |   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC) |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>28 July</u> , 19 <u>86</u> , to <u>10 Oct</u> , 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>10 Oct</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |  |  |   |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>R. Holodrubetz MD</u>   |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>10/13/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HOLODRUBETZ   |  |  |  | 22e. ADDRESS<br>600 Light St Baltimore                              |  |  |  |  |  |   |  |   |  |

|  |  |                       |  |  |  |   |  |                            |  |
|--|--|-----------------------|--|--|--|---|--|----------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                             |  | 23b. DATE<br>10/16/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown 21220 Md |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Home West 4300 Wabash Avenue |  |                       |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986                        |  | 25b. REGISTRAR'S SIGNATURE |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please enclose early in papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

7/21/54

100-50014



*[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]*

00-21099

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 28346

1- FOR  
STATE  
REGISTRAR

|   |        |  |                                   |  |                                 |  |   |  |  |      |  |
|---|--------|--|-----------------------------------|--|---------------------------------|--|---|--|--|------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |        |  |                                   | 2a DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |                                 |  |   | 2b HOUR  |  |      |  |
| Theodore Knight   |        |  |                                   | 10-10 19 86  |                                 |  |   | M  |  |      |  |
| 3 SEX   | 4 RACE | 5 DATE OF BIRTH<br>MONTH DAY YEAR  | 6 AGE (IN YEARS<br>LAST BIRTHDAY) | 7 IF UNDER 1 YR<br>MONTHS DAYS   | 8 IF UNDER 24 HRS.<br>HOURS MIN | 2c DATE<br>PRONOUNCED<br>DEAD  |   | 2d HOUR  |  | 2e   |  |
| M   | B      | 3 9 07   | 79 YRS.                           |  |                                 | 10-11 19 86  |   | 9:30   |  | p. M |  |
| 7a BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |        | 7b CITIZEN OF WHAT COUNTRY?  |                                   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |  |      |  |
| N. C.   |        | U. S. A.   |                                   |  |                                 | Baltimore City, MD.  |   |  |  |      |  |
| 10 CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                   |  |                                 | 12a USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |   | 12b KIND OF BUSINESS<br>OR INDUSTRY  |  |      |  |
| Baltimore   |        | 4703 Ivanhoe Avenue  |                                   |  |                                 | Brick Mason  |   |  |  |      |  |
| 13a STATE   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| MD.   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 13b. COUNTY   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| Balto   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 13c. CITY OR TOWN   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 4703 Ivanhoe Ave  |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 13e. STREET ADDRESS   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 21212   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| William Knight  |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| Winnie Wilson   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| NO  |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 16b. SOCIAL SECURITY NO.  |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 241-16-0943   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 17 INFORMANT<br>ADDRESS   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| Edna Blandon 425 Central PK West NY, NY   |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Intracerebral Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |        |  |                                   |  |                                 |  |   |  |  |      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |        |  |                                   |  |                                 |  |   |  |  |      |  |
| 19a DATE OF OPERATION   |        |  |                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                 |  |   | 20 AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |      |  |
| 21a EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |        |  |                                   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |  |      |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |        |  |                                   | 21e PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |                                 | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |  |      |  |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |        |  |                                   |  |                                 |  |   |  |  |      |  |
| ACTUAL<br>SIGNATURE   |        |  |                                   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |                                 |  |   | DATE<br>SIGNED 10-12-86  |  |      |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |        |  |                                   | ADDRESS  |                                 |  |   |  |  |      |  |
| Charles P. Kokes, M.D.  |        |  |                                   | 111 Penn St., Balto., Md. 21201  |                                 |  |   |  |  |      |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |        | 23b DATE   |                                   | 23c NAME OF CEMETERY OR CREMATORY  |                                 |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |      |  |
| Burial  |        | 10-18-86   |                                   | Rose Hill Cemetery   |                                 |  | Linden N. J.                              |  |  |      |  |
| 24 FUNERAL DIRECTOR<br>NAME   |        |  |                                   | ADDRESS  |                                 |  | 25a DATE REC'D. BY REGISTRAR              |  |  |      |  |
| Wm. C. Brown  |        |  |                                   | 1206 W. North Ave  |                                 |  | OCT 15 1986                               |  |  |      |  |
|   |        |  |                                   |  |                                 |  | 25b REGISTRAR'S SIGNATURE                 |  |  |      |  |
|   |        |  |                                   |  |                                 |  | John D. ...                               |  |  |      |  |

20% COTTON FIBER

100% COTTON

100% COTTON



0-21695

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28347  
REG. NO.1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |                             |  |  |
|---|--|--|---|---|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM B. KNOTT</b>                       |  |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>16</b> YEAR <b>86</b> |   | 2b. HOUR <b>1100 P</b><br>M |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>March</b> DAY <b>15</b> YEAR <b>1906</b>   |                             | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>80</b><br>YRS MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lincoln Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>   |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Coffee Company</b>                   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |   | 13b. COUNTY<br><b>Montgomery</b>  |                             | 13c. CITY OR TOWN<br><b>Rockville</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Spencer</b> MIDDLE LAST <b>Knott</b>                |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Not Available</b> MIDDLE LAST  |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |   | 17. INFORMANT (Son)<br><b>Jerome K. Knott</b>   |                             | ADDRESS <b>1614 Bradley Ave</b><br><b>Rockville, MD 20851</b>                |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH Enter only one cause on line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b><br>DUE TO OR AS A CONSEQUENCE OF<br><b>Bilateral CVA with Hemiparesis</b><br>DUE TO OR AS A CONSEQUENCE OF<br><b>Dysphagia</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10.   |  |   |

## MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-31-86</b> to <b>10-16-86</b> , that (I) (we) last saw the deceased alive on <b>10-16-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Ali I. Baykaler, MD</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>10-17-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALI I. BAYKALER</b>  |  |  |  | 22e. ADDRESS<br><b>831 Poplar Grove St. Bal. 21216</b>                               |  |   |  |

|   |  |                                      |  |   |  |   |  |
|---|--|--------------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>October 20, 1986</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Maryland</b> STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey</b>        |  |                                      |  | 25a. DATE REC'D BY REGISTRAR <b>OCT 22 1986</b>       |  |   |  |
| 7557 Wisconsin Ave., Bethesda, Maryland                       |  |                                      |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2, and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

KNOLL 10-10-82 11:24

10-10-82 11:24  
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10-10-82 11:24  
10-10-82 11:24



|   |  |  |                      |   |   |   |  |  |
|---|--|--|----------------------|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><b>ANNA</b>   | MIDDLE<br><b>NMN</b> | LAST<br><b>KOLTKO</b>   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/23/86</b>                     |   | 2b. HOUR<br><b>10:27</b><br>M  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>  |                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 6 1919</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hungry</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b><br>MD.                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>   |                      | 13c. CITY OR TOWN<br><b>Hanover</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Wintekorn</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Kaiser</b>  |                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |   |   |  |  |
| 16b. <b>216-34-844</b><br><del>219-30-3727</del>  |  | 17. INFORMANT ADDRESS<br><b>Nicholas Koltko 7134 Ridge Rd., Hanover, Md. 21076</b>   |                      |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Insulin dependent Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |                      |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |                      |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                      |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that I (this hospital) attended the deceased from <b>9-1</b> <b>86</b> , to <b>9-23</b> <b>86</b> that I (we) last saw the deceased on <b>9-23</b> <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                      |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Katherine Traczuk MD</b>   |  | DEGREE<br><b>MD</b>  |                      | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>                          |   | 22c. DATE SIGNED<br><b>9-23-86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KATHERINE TRACZUK</b>   |  | 22e. ADDRESS<br><b>33 Winesap Ct. Old Orchard's APT. Catonsville MD 21228</b>  |                      |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>   |  | 23b. DATE<br><b>9/26/86</b>  |                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Md.</b>                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Gary L. Kaufman 5695 Main St., Elkridge, Md. 21227</b>   |  |  |                      | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 24 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the funeral home permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

BP

1. Name of the person: [illegible]  
2. Date of birth: [illegible]  
3. Place of birth: [illegible]  
4. Sex: [illegible]  
5. Marital status: [illegible]  
6. Occupation: [illegible]  
7. Address: [illegible]  
8. Telephone number: [illegible]  
9. Signature: [illegible]  
10. Date: [illegible]

[Faint, illegible text, possibly a continuation of a form or document]

00-20163

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON-MED DR. ZANE PER MR. FREEMAN TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed with the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 86 28349<br>REG. NO. |  |
|--|--|---|--|---|--|--|--|--|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WESLEY George KONE   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 07, 1986                        |  |  | 2b. HOUR A<br>1:30 M   |  |                      |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 20 45   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>41 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, CITE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Artist           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employ   |  |                      |  |
| 13a. STATE<br>Maryland   |  |   |  |   | 13b. CITY OR TOWN<br>Balto   |  | 13c. STREET ADDRESS / ZIP CODE<br>3350 Strickland St. 21229        |  |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alfred Kone  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl E. Wearley              |  |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>-----                                      |   | 17. INFORMANT<br>ADDRESS<br>Nancy Rickels Same as #13                          |  |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastrointestinal bleeding</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Small bowel lymphoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acquired Immuno-deficiency Syndrome</u>                                 |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>15 days</u><br><u>months</u><br><u>1 year</u>                           |  |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |  |  |  |  |                      |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 6, 1986</u> to <u>October 7, 1986</u> , that (I) (we) lost<br>saw the deceased alive on <u>October 7, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |                      |  |
| 22b. SIGNATURE<br><u>S. Melley</u><br>DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   | 22c. DATE SIGNED<br><u>10/7/86</u>   |  |  |  |  |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Susan Melley</u>   |  |   |  |   | 22e. ADDRESS<br><u>The Johns Hopkins Hospital</u> 21205                        |  |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  |   | 23b. DATE<br><u>10-8-86</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Park Cem.</u>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Md.</u> |  |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>MacNabb Funeral Home Catonsville Md.</u>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 07 1986</u>                            |  |  |  |  |                      |  |



00-20833

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28550

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Parker F. Koons</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 6, 1986</b>   |   | 2b. HOUR<br><b>1030 P M</b>   |   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 27, 1905</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS                              |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.            |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Garden Village Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Driver</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Transit</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Eugene Koons</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella F. Wilhelm</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215 09 3549</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Ellen Mary Koons 3808 Woodlea Ave. -06</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspirational Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recent Cerebrovascular Accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Congestive Heart Failure</b>   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>JAN 19 86</b> , to <b>OCT 6 19 86</b> , that (1) (we) last saw the deceased alive on <b>OCT 6 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) (we) (did) (did not) view the body after death.  |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Harold H Bone</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>10/17/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>  |   | 23b. DATE<br><b>10/9/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>  |   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE  |   |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

I, [illegible]

[illegible]

I, [illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

00-21992

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28351  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |  |                           |  |
|--|--|--|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN KORNAFEL</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/18/86</b> |  | 2b. HOUR<br><b>1149AM</b> |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/3/36</b>                            |                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>SOVIET UNION</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS                               |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>              |                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MECHANIC</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWENS ILLINOIS, INC.</b>   |  |  |                           |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN KORNAFEL</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>1301 ANGLESEA ST. 21224</b>               |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>301-28-8400</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JOHN RADD 623 S. ROBINSON ST. 21224</b>         |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>PERICARDIAL TAMPONADE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>VENTRICULAR WALL RUPTURE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 MIN.</b><br><b>60 MIN.</b><br><b>60 MIN.</b> |  |  |  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>ANTERIOR MI, COPD, SEIZURE DISORDER, RETROPERITONEAL BLEED.</b>   |  |  |  |  |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                           |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 3</b> 19 <b>86</b> to <b>OCT 18</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>OCT 18</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |                           |  |
| 22b. SIGNATURE<br><b>Scott Carnivale MD</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>10/18/86</b>  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SCOTT CARNIVALE</b>  |  | 22e. ADDRESS<br><b>FRANCIS SCOTT KEY HOSPITAL</b>  |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>OCT. 23 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MICHAEL UCR. CFM</b>              |                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>   |  |  |  |  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LILLY + ZEILER, INC. 1901 EASTERN AVE. 21224</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1 and 2 and deliver them to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are visible.]*





00-21248

Item # 1,5 &amp; 6, Film G 620.10.21.86 ra

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 8 3 3 2

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Carlyn <del>Kastusch</del> Kostusch   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/17/86   |   | 2b. HOUR<br>7 am   |  |
| 3 SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10/7/23 24  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 61 YRS                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3025 Elizabeth Ave. 21229 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Aid |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Nurse   |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore City                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Kastusch   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Loos   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-20-7811  |   | 17. INFORMANT<br>ADDRESS<br>Doris Collison 1246 Poplar Ave. 21227              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>colon cancer</u>   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>minute<br>years   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>MA Dobyns  |  |   |   | 22c. DATE SIGNED<br>10/17/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MA Dobyns   |  |   |   | 22e. ADDRESS<br>2822 Hollins Ferry Road  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/20/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                       |  |
| 23d. LOCATION<br>(CITY OR TOWN COUNTY STATE)<br>Baltimore City, Maryland   |  | 23e. DATE REC'D. BY REGISTRAR<br>OCT 17 1986  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ambrose, Inc. 1328 Sulphur Spring Rd. 21227  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1986                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Jana Davidson  |  |   |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be performed at the scene of death.

BP

RECEIVED 10/11/1964

00-20708

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8028555  
REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Kotrla Jr.</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>8</b> YEAR <b>86</b>  |  | 2b. HOUR<br><b>11:55 P.M.</b>  |  |
| 3. SEX<br><b>M Male</b>   |  | 4. RACE<br><b>W White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>25</b> YEAR <b>1919</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lochman Va Hospital</b> |  | 12a. OCCUPATION (TYPE)<br><b>Mechanic</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Exxon Corp.</b>  |  |
| 13a. COUNTY<br><b>MD</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>3511 Erdman Ave 21213</b>  |  |  |  |
| 14. FATHER'S NAME<br>(TYPE OR PRINT)<br><b>Joseph</b>   |  | 15. MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT)<br><b>Elizabeth</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-07-1046</b>   |  |
| 17. INFORMANT<br><b>John Kotrk</b>  |  | 18. ADDRESS<br><b>247 Sandhill road Essex 21221</b>   |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Adenocarcinoma of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastasis to T4 spine</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7/85 - 10/86</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Methicillin Resistant Staph Aureus</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>0</b>  |  | 19b. CONDITIONS FOR WHICH OPERATION WAS PERFORMED<br><b>0</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF OTHER, INDICATE MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7</b> 19 <b>85</b> to <b>10</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>10/8</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) |  |   |  |   |  |  |  |
| 23a. SIGNATURE<br><b>Mark C Basham</b>  |  | 23b. DEGREE<br><b>MD</b>  |  | 23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 23d. DATE SIGNED<br><b>10/8/86</b>   |  |
| 23e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark C Basham</b>   |  | 23f. ADDRESS<br><b>6804 Bonnie Ridge Dr Apt T-1 Balt Md.</b>  |  |   |  |  |  |
| 23g. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23h. DATE<br><b>10-11-86</b>  |  | 23i. NAME OF CEMETERY OR CREMATORY<br><b>Bohemian Nat'l Cem.</b>  |  | 23j. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Schimmunek Funeral Home, Inc.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>10/10/86</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |  |  |
| 26. ADDRESS<br><b>3331 Brehms Lane, Baltimore, Md. 21236</b>  |  |   |  |   |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



00-22133

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

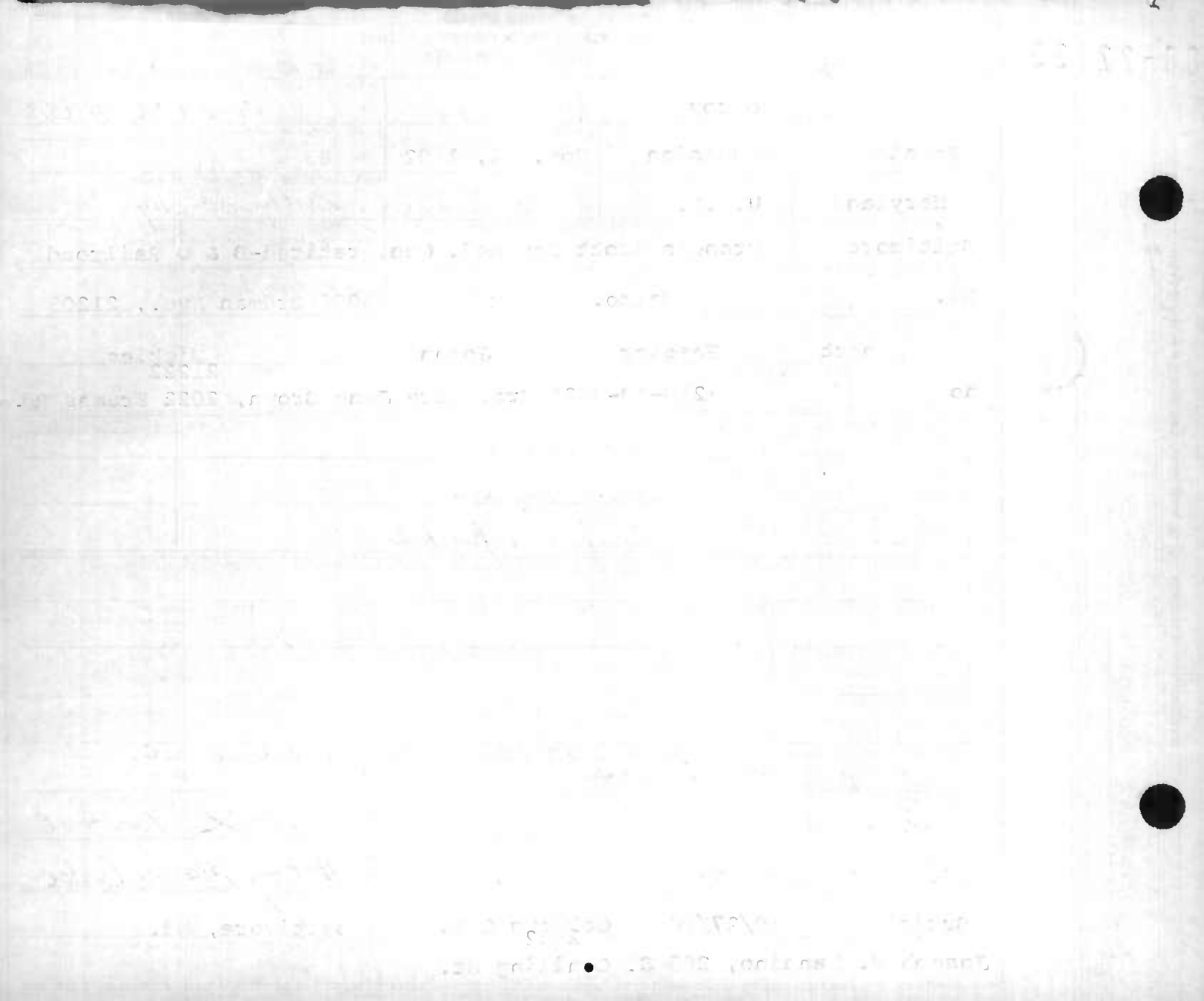
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-6 NO. 28354

|  |  |   |  |   |   |  |   |   |   |
|--|--|---|--|---|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Agnes Holroyd Kowalewski</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 24 86</b>                 |   |   | 2b. HOUR<br><b>4:05 PM</b>   |   |   |   |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 11, 1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>   |   | 7b. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Med. Cen.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK, FOR MOST OF WORKING LIFE)<br><b>retired-B. &amp; O. Railroad</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |   | 13e. STREET ADDRESS / ZIP CODE<br><b>5006 Erdman Ave., 21205</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Hessler</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Joanna Nickles</b>  |   |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                |   |
| 16b. SOCIAL SECURITY NO.<br><b>A219-10-5323</b>  |  |   |  | 17. INFORMANT<br><b>Mrs. Mary Jane Brown, 2022 Frames Rd.</b>   |   |  |   | ADDRESS <b>21222</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>myocardial infarction</b>   |  |   |  |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>   |  |   |  |   |   |  |   |   |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) |  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 23</b> , 19 <b>86</b> , to <b>OCT 24</b> , 19 <b>86</b> , that (we) lost<br>saw the deceased alive on <b>OCT 24</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |   |   |
| 22b. SIGNATURE<br><b>Paul T. Diannino</b>  |  |   |  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>10-24-86</b>                                 |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul T. Diannino</b>   |  |   |  |   | 22e. ADDRESS<br><b>Francis Scott Key Marine Center</b>                          |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>10/27/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cem.</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |   |   |
| 24. FUNERAL DIRECTOR<br><b>Joseph N. Zannino, 263 S. Conkling St.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1986</b>                             |  | 25b. REGISTRAR'S SIGNATURE  |   |   |

BP



00-2105

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 2 8 3 5 5

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MORRIS KRAVETZ</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Oct. 4, 1986</b>                          |   | 2b. HOUR<br><b>4:30 P M</b>                                      |
| 3. SEX<br><b>M</b><br><b>MALE</b>  | 4. RACE<br><b>W</b><br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02/02/02</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b><br>YRS MONTHS DAYS HOURS MIN.                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>RUSSIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALTO</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INVENTOR</b> |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>MARTIN MARIETTA C</b> |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTO</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISAAC KRAVETZ</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CYRIL WOHL</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215-09-2097</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. ROSE KRAVETZ</b><br><b>4103 CREST HEIGHTS RD. BALTO. MD 21215</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/10/83</b> 19 <b>86</b> , to <b>10/4</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>10/4</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.      |   |   |   |   |  |
| 22b. SIGNATURE<br><b>HANADI SHAMKHANI</b> MD<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   |   |   | 22c. DATE SIGNED<br><b>10/4/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HANADI SHAMKHANI</b>   |   | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTO.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>OCT. 6, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHEVRA AHAVAS CHESED</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN BALTO. MD</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                              |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE  |   |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general description of the project. It includes the title, the purpose of the study, and the scope of the work. This section is intended to provide a clear and concise overview of the project for the reader.

2. The second part of the report is a detailed description of the methodology used in the study. This section includes information about the data sources, the sampling methods, and the statistical techniques used to analyze the data. The purpose of this section is to provide a clear and detailed account of the methods used in the study so that the results can be interpreted correctly.

3. The third part of the report is a description of the results of the study. This section includes a summary of the findings, a discussion of the results, and a conclusion. The purpose of this section is to provide a clear and detailed account of the results of the study so that the reader can understand the findings and the conclusions drawn from the data.

4. The fourth part of the report is a bibliography of the sources used in the study. This section includes a list of the books, articles, and other sources that were consulted during the study. The purpose of this section is to provide a clear and detailed account of the sources used in the study so that the reader can verify the information presented in the report.





00-20167

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARCELLUS M. KRUEGER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 01 '86 |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Cauc.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 23 1923  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1542 Charlotte Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Millright  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Gen'l Motors  |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>1542 Charlotte Ave., 21224  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Krueger   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Lippert   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II 219-16-8818   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Elizabeth Krueger - 1542 Charlotte Ave. 21224  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pulmonary metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>colon carcinoma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>-<br>1 yr.<br>2.5 yrs. |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 22</u> 19 <u>84</u> , to <u>Sept 30</u> 19 <u>86</u> , that I (we) lost<br>saw the deceased alive on <u>Sept 30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>H. B. Grochow</u>   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/1/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. B. GROCHOW   |  | 22e. ADDRESS<br>601 N. WOLFE ST 21205  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/04/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Dabrowski - 1005 Dundalk Ave., 21224  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 07 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John T. ...</u>   |  |

MEDICAL CERTIFICATION

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9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

73105-00

2835  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | MIDDLE   |  | LAST   |  | REG. NO.   |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR   |  |
| GEORGE   |  | F.   |  | KUDRNA   |  | 10-9-86  |  | 19   |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | 7. IF UNDER 1 YR.  |  | 7. IF UNDER 24 HRS.  |  |
| MALE   |  | CAUCAS.  |  | 09 10 01   |  | 85 YRS.  |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED   |  | NEVER MARRIED  |  | DIVORCED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| MARYLAND   |  | USA  |  | WIDOWED  |  | X  |  | BALTIMORE CITY   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 12c. DATE OF DEATH   |  | 12d. HOUR  |  |
| Baltimore  |  | 809 N. Port Street   |  | MECHANIC   |  | AUTOMOTIVE   |  | 10-9-86  |  | 9:30P  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  | 13f. STREET ADDRESS  |  |
| MARYLAND   |  | -----  |  | BALTIMORE  |  | YES X NO   |  | 809 N. PORT ST. 21205  |  | 21205  |  |
| 14. FATHER'S NAME  |  | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME   |  | MIDDLE   |  | LAST   |  |
| JOSEPH   |  | KUDRNA   |  | BARBARA  |  | ADDRESS  |  | -----  |  | -----  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  | 17. INFORMANT  |  | ADDRESS  |  |
| NO   |  | 213-10-4449  |  | GEORGE A. KUDRNA   |  | 7287 GOUGH ST.   |  | 7287 GOUGH ST.   |  | 7287 GOUGH ST.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |
| PART I DEATH WAS CAUSED BY:  |  | PART I DEATH WAS CAUSED BY:  |  | PART I DEATH WAS CAUSED BY:  |  | PART I DEATH WAS CAUSED BY:  |  | PART I DEATH WAS CAUSED BY:  |  | PART I DEATH WAS CAUSED BY:  |  |
| IMMEDIATE CAUSE (a)  |  | IMMEDIATE CAUSE (a)  |  | IMMEDIATE CAUSE (a)  |  | IMMEDIATE CAUSE (a)  |  | IMMEDIATE CAUSE (a)  |  | IMMEDIATE CAUSE (a)  |  |
| Arteriosclerotic cardiovascular disease  |  | Arteriosclerotic cardiovascular disease  |  | Arteriosclerotic cardiovascular disease  |  | Arteriosclerotic cardiovascular disease  |  | Arteriosclerotic cardiovascular disease  |  | Arteriosclerotic cardiovascular disease  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |
| (b)  |  | (b)  |  | (b)  |  | (b)  |  | (b)  |  | (b)  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |
| (c)  |  | (c)  |  | (c)  |  | (c)  |  | (c)  |  | (c)  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |
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| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 19b  |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1-23. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 200 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 BP \_\_\_\_\_  
25M  
DHMH - 17  
(VR A15 ME (5))

100

20% COTTON FIBRE

WINTER



00-22206

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28358

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA (nmn) KULIS</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 23, 1986</b>   |  | 2b. HOUR<br><b>1:45<sup>P</sup><sub>M</sub></b>  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 11, 1921</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Harford</b>   | 13c. CITY OR TOWN<br><b>Bel Air</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George --- Adamik</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary --- Sivak</b>  |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no ---</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>181-14-7534</b>  |  | 17. INFORMANT<br>Address <b>Bel Air, Md. 21014</b><br><b>Melvin R. Kulis, 511 E. Courtland Place</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (d) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Infarction</b>  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 minutes</b><br><b>4 days</b><br><b>4 weeks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>10/16</b> , 19 <b>86</b> , to <b>10/23</b> , 19 <b>86</b> , that (ii) (we) lost<br>saw the deceased alive on <b>10/23</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (i) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>D.L. Clemens, M.D., Ph.D.</b>   |  | DEGREE<br><b>M.D., Ph.D.</b>  |  | 22c. DATE SIGNED<br><b>10/23/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.L. Clemens, M.D. Ph.D.</b>   |  | 22e. ADDRESS<br><b>600 N. Wolfe St</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Oct. 27, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial Gardens</b>                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Howard K. McComas III, Abingdon, Md. 21009</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bel Air Harford Md.</b>  |  | 25a. DATE REC'D. BY REG.<br><b>OCT 27 1986</b>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the (reverse) page, should be detached for use as the burial-transit permit. Then please remove carbon paper copy and file in the (reverse) page.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be signed by a medical examiner.

BP

355

2 553 07 86  
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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

00-20867

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                      |  |   |   |  |  |  | REG. NO. 86 28359   |  |
|--|--|--|----------------------|--|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |                      |  |   |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ALBERT P KURLOWICZ   |  |  |                      |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 4 86   |   |  | 2b. HOUR<br>5:50 PM  |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>C   |                      | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 28 19  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CONN.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                       |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. OF MD HOSPITAL |                      |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WAREHOUSE M. |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN<br>MD BALTO.   |  |  |                      |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13c. STREET ADDRESS / ZIP CODE<br>824 W. LOMBARD ST. 21201                     |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Unknown   |  |  |                      |  | 16b. SOCIAL SECURITY NO.<br>041-16-4340   |   | 17. INFORMANT ADDRESS<br>Patient/HOSP BALTO, MD<br>UNIV. OF MD HOSP.           |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>massive CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u> |  |  |                      |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
|  |  |  |                      |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |                      |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)  |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/10/86</u> , 19 <u>86</u> , to <u>10/4</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |  |                      |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br>RW DALY  |  |  |                      |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  |  | 22c. DATE SIGNED<br>10/4/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RW DALY   |  |  |                      |  | 22e. ADDRESS<br>MD 22 S. Greene St Balt MD  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  |  | 23b. DATE<br>10-7-86 |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board   |  |  |                      |  | ADDRESS<br>Balto., Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 10 1986                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall |   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |                                   |  |  |   |  |
|---|--|---|---|--|-----------------------------------|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   | REG. NO. 8028500   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   | REG. NO. 8028500   |  |   |  |
| STEVEN A. LACROIX   |  | OCTOBER 31, 1986  |   | 4:40 P.M.  |                                   |  |  |   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.   |  |   |  |
| Male  | White  | MONTH 10 DAY 7 YEAR 1953  | 33 YRS.   | MONTHS DAYS  |                                   | HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |  |  |   |  |
| Massachusetts   | U. S. A.   |   | BALTIMORE CITY MD.  |  |                                   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |   |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL   |   | Production Manager  |  | Paper                             |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE    |  |  |   |  |
| Maryland  |  | Anne Arundel  | Severna Park  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 341 Wellerburn Avenue 21146       |  |  |   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |  |  |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |   |  |                                   |  |  |   |  |
| Arthur J. LaCroix   |  | Marjorie A. Forrest   |   |  |                                   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                   |  |  |   |  |
| No  |  | 015-44-0364   |   | Park, Maryland<br>Kimberly LaCroix 341 Wellerburn Ave. Severna                 |                                   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Colon Carcinoma</u>  |  |   |   |  |                                   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 months</u> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |   |   |  |                                   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |  |                                   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |                                   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
|   |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |  |  |   |  |
| 22a. I certify that (H) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>86</u> , to <u>10/31</u> , 19 <u>86</u> , that (H) (we) lost<br>saw the deceased alive on <u>10/31</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (H) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Shanti Ramesh</u>  |   | DEGREE<br><u>Resident Physician</u>  |                                   | 22c. DATE SIGNED<br><u>10/31/86</u>                            |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |                                   |  |  |   |  |
| SHANTI RAMESH   |  | 600 N. WOLFE ST. 21205  |   |  |                                   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |   |  |
| Burial  |  | 11-4-86   |   | St. Mary Cemetery  |                                   | Needham, Norfolk, Mass.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |   | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |   |  |
| MARZULLO FUNERAL SERVICE, UPPERCO, MD   |  |   |   | NOV 3 - 1986   |                                   | Julia Benson-Kendall   |  |   |  |

BP \_\_\_\_\_

10-22022

FOR COTTON FILLS

WALTON

00-22835

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 8 3 0 1

|  |   |   |                       |   |                                   |
|--|---|---|-----------------------|---|-----------------------------------|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH   |                       | 2b. HOUR  |                                   |
| DOUGLAS  |   | OCTOBER 30, 1986  |                       | 3:15 am   |                                   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  |                       | 6. AGE  |                                   |
| MALE   | WHITE   | 2 12 51   |                       | 35 YRS.   |                                   |
| 7a. BIRTHPLACE   | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                   |
| Virginia   | U.S.A.  |   |                       | BALTIMORE CITY MD.  |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |   | 12a. USUAL OCCUPATION |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE  | MARYLAND GENERAL HOSPITAL                               |   | Shipping Clerk        |   | Pharmaceutical Manuf.             |
| 13a. USUAL RESIDENCE   |   | 13b. COUNTY   |                       | 13c. CITY OR TOWN   |                                   |
| Maryland   |   |   |                       | Baltimore   |                                   |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |                       | 16. ADDRESS   |                                   |
| Joe  |   | Blanche   |                       | Cassidy   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |   | 16b. SOCIAL SECURITY NO.  |                       | 17. INFORMANT   |                                   |
| NO   |   | 240-08-3247   |                       | Blanche C. Bates 161 S. Hunter St. 24541                            |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):   |   |   |                       |   |                                   |
| PART 1. DEATH WAS CAUSED BY:   |   |   |                       |   |                                   |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST   |   |   |                       |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF SEPTIC SHOCK  |   |   |                       |   |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |   |   |                       |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |                       |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |   |   |                       |   |                                   |
| Disseminated Intravascular Coagulation   |   |   |                       |   |                                   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                       | 20a. AUTOPSY?   |                                   |
| OCTOBER 29, 1986   |   | SUSPECTED PERFORATED VISCUS   |                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY   |                       | 21c. HOW INJURY OCCURRED  |                                   |
|  |   | HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                       | [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]               |                                   |
| 21d. INJURY OCCURRED   |   | 21e. PLACE OF INJURY  |                       | 21f. LOCATION   |                                   |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |   | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]  |                       | CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (X) (this hospital) attended the deceased from OCTOBER 29, 19 86, to OCTOBER 30, 19 86, that (X) (we) last saw the deceased alive on OCTOBER 30, 19 86, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If (e) (d) (c) (b) (a) view the body after death. |   |   |                       |   |                                   |
| 22b. SIGNATURE   |   | DEGREE  |                       | 22c. DATE SIGNED  |                                   |
| La Rondelle  |   | M.D.  |                       | 10/30/86  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |                       | 22f. REGISTRAR'S SIGNATURE  |                                   |
| LA RONDELLE  |   | C/O MARYLAND GENERAL HOSPITAL   |                       | JULIA RANDON RONDELLE   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE   |                       | 23c. NAME OF CEMETERY OR CREMATORY                                  |                                   |
| Burial   |   | 11/2/86   |                       | Highland Burial Park  |                                   |
| 24. FUNERAL DIRECTOR   |   | 24b. ADDRESS  |                       | 24c. DATE REC'D. BY REGISTRAR                                       |                                   |
| NAME   |   | 24a. ADDRESS  |                       | 24b. DATE REC'D. BY REGISTRAR                                       |                                   |
| Hubbard Funeral Home, Inc.   |   | 4107 Wilkens Ave.   |                       | OCT 31 1986   |                                   |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



023383 NOV 10 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28362

|   |                 |   |   |   |  |   |   |  |
|---|-----------------|---|---|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>ESTHER LAMBRUCO   |                 |   | 2a DATE KNOWN OF DEATH<br>10/18/86        |   |  | 2b HOUR<br>3:50 P   |   |  |
| 3 SEX<br>Female   | 4 RACE<br>Black | 5 DATE OF BIRTH<br>46 YRS.  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c DATE PRONOUNCED DEAD<br>10/18/86                          | 7d HOUR<br>3:50 P   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |                 | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |                 | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1205 E. North Ave. |   |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b KIND OF BUSINESS OR INDUSTRY          |  |
| 13a STATE<br>Md.  |                 | 13b COUNTY  |   | 13c CITY OR TOWN<br>Balto.  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |                 | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Unkn.   |  |   |   |  |
| 16b SOCIAL SECURITY NO.   |                 | 17 INFORMANT  |   |   | ADDRESS  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertrophic Cardiomyopathy<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                 |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br>Pericarditis  |                 |   |   |   |  |   |   |  |
| 19a DATE OF OPERATION   |                 | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20 AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |
| 21a EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                 | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                 | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                 |   |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><i>William M. Zane</i>  |                 | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |   |   |  | DATE SIGNED<br>10/19/86   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>William M. Zane, M.D.   |                 | ADDRESS<br>111 Penn St.   |   |   |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |                 | 23b DATE<br>10-29-86  |   | 23c NAME OF CEMETERY OR CREMATORY   |  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |                 |   |   | ADDRESS<br>Balto., Md.  |  | 25a DATE REC'D. BY REGISTRAR<br>NOV 05 1986   |   | 25b REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

93819 MDTIO 2002

2002 COTTON BOND



1-11-01 808851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M/7-84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28363

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ETHEL Rebecca LANDE FELD</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 / 20 / 86</b>             |   |  | 2b. HOUR<br><b>11 40 A.M.</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 9 01</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL 1650 pike</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOMEMAKING</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>501 W FRANKLIN ST 21201</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Kirckhoff</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Ault</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>216242174</b>  |  | 17. INFORMANT ADDRESS<br><b>Thelma Wistland 4600 Silver Spring Rd. 21236</b>                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/18</b> , 19 <b>86</b> , to <b>10/20</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Don Winkberg</b>   |  |   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10/20/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Don Winkberg</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>301 S. HANOVER ST.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>10-23-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Don Winkberg</b>   |  |  |  |

MEDICAL CERTIFICATION

84555 28

0051661





00-21339

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28364  
REG. NO.

|   |   |   |   |  |   |  |  |                                     |  |
|---|---|---|---|--|---|--|--|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE  | LAST   | 2a. DATE OF DEATH   | MONTH                                      | DAY  | YEAR                                | 2b. HOUR   |
| ROBERT L LARDNER SR   |   |   |   |  | OCTOBER 15,   |  |  | 1986                                | 2:00 <sup>P</sup> M  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |                                     |  |
| Male  | White   | 9-30-1933   |   | 53   | MONTHS DAYS   |  | HOURS MIN.   |                                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |                                     |  |
| Md.   | U.S.A.  |   |   | BALTIMORE CITY MD.   |   |  |  |                                     |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |                                     |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL  |   | Dispatcher  |  | Trucking  |  |  |                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE   |   |  |  |                                     |  |
| Md.   |   | Balto.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 858 Benninghaus Rd. 21212  |   |  |  |                                     |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |   |  |   |  |  |                                     |  |
| FIRST MIDDLE LAST<br>Thomas A. Lardner  |   | FIRST MIDDLE LAST<br>Marguerite Fitzgerald  |   |  |   |  |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |   |  |  |                                     |  |
| No  |   | 212-32-4352   |   | Patricia A. Lardner, Same as 13e   |   |  |  |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>  |   |   |   |  |   |  |  |                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1855 hours/min</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Anoxic brain death</u>   |   |   |   |  |   |  |  |                                     | <u>10 days</u>   |
| (c) <u>Cardiopulmonary arrest</u>   |   |   |   |  |   |  |  |                                     | <u>10 days</u>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>N/A</u>   |   |   |   |  |   |  |  |                                     |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                     |  |
| N/A   |   |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |                                     |  |
|   |   |   |   | N/A  |   |  |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET  |   | CITY OR TOWN                               |  | COUNTY                              | STATE  |
|   |   |   |   |  |   |  |  |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/6/86</u> , 19 <u>86</u> , to <u>10/15</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. <u>2-58</u> |   |   |   |  |   |  |  |                                     |  |
| 22b. SIGNATURE<br><u>Mun K. Hong, MD</u>  |   |   |   | DEGREE<br><u>MD</u>  |   |  |  | 22c. DATE SIGNED<br><u>10/15/86</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Mun K. Hong, MD</u>   |   |   |   | 22e. ADDRESS<br><u>Johns Hopkins Hospital</u>                                  |   |  |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                                     |  |
| Burial  |   | 10-18-86  |   | St. Marys Govans   |   | Balto., Md.                                |  |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>  |   |   |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                 |  |                                     |  |
|   |   |   |   | OCT 16 1986  |   | <u>John Davidson</u>                       |  |                                     |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The license requires that a death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in the funeral director's office, it should be detached for use as the burial permit. Then please return this certificate to the funeral director's office. It is to be filed with the State Dept. of Health and Mental Hygiene prior to burial. (If the funeral home is not licensed by the State, it must be filed with the State Dept. of Health and Mental Hygiene.) (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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1999

00-20729

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28365  
REG. NO.

|  |   |   |   |  |   |  |
|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST<br>CARL   | MIDDLE<br>Michael   | LAST<br>LARSON JR.   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 7, 1986  | 2b. HOUR P<br>4:01<br>M  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 24, 1969   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>17 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student  | 12b. KIND OF BUSINESS OR INDUSTRY<br>- - -  |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland  |   | 13b. COUNTY<br>Anne Arundel   | 13c. CITY OR TOWN<br>Pasadena                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS / ZIP CODE<br>8381 Penn Dr. / 21122   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Carl M. Larson, Sr.  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Brenda - Johnson   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>- -  |   | 12. INFORMANT<br>ADDRESS<br>8381 Penn Drive.<br>Brenda & Garry, Ingle / Pasadena, Md. 21122  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 minute</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   |   |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Overwhelming fungal sepsis</u>   |   |   |   |  |   | <u>2 weeks</u>   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aplastic Anemia</u>  |   |   |   |  |   | <u>8 yrs</u>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>None</u>  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 22, 1986</u> to <u>October 7, 1986</u> , that (I) (we) last saw the deceased alive on <u>October 7, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Ada Hamel MD</u>  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>10/7/86</u>                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>HAMOSH</u>   |   |   |   | 22e. ADDRESS<br><u>JHA 600 N Wolfe St, Balto, MD 21205</u>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>Oct. 11, 86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Mem. Gard. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>- - Baltimore, Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 10 1986</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reimburse the funeral director for the cost of the permit. Please return the permit to the State Dept. of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Maryland 21201.

IMPORTANT: If item 21 is marked "AT WORK" or "NOT AT WORK", the physician must be a duly licensed physician or medical examiner.

84 2830

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FOR OFFICIAL USE ONLY

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0-22782

1-  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28366  
REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES EDWARD LASSITER, SR.   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 26, 1986   |  | 2b. HOUR<br>4:50 A.M.   |
| 3. SEX<br>Male  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 18 19  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD                                      |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1509 NORTH DECKER AVENUE |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction                                    |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1509 N. Decker Avenue 21213                        |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Shelton Lassiter  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elsie ?  |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  | 16b. SOCIAL SECURITY NO.<br>225-12-6806   | 17. INFORMANT<br>ADDRESS<br>Janet Lassiter 1019 Brentwood Avenue  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>with bone</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastases</u>   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 year   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK hospice  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (this hospital) attended the deceased from <u>Oct 24</u> 19 <u>86</u> to <u>Oct 26</u> 19 <u>86</u> , that (we) last saw the deceased alive on <u>Oct 25</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death. |   |   |   |  |   |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W.B. Daniels, Jr.  |   | 23b. DATE<br>11/1/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                             |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.  |   | 23e. DATE REC'D. BY REGISTRAR<br>OCT 31 1986  |   | 23f. REGISTRAR'S SIGNATURE<br>John S. Sanders  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Homes 1101 EAST North Avenue  |   |   |   |  |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the must be notified at once.

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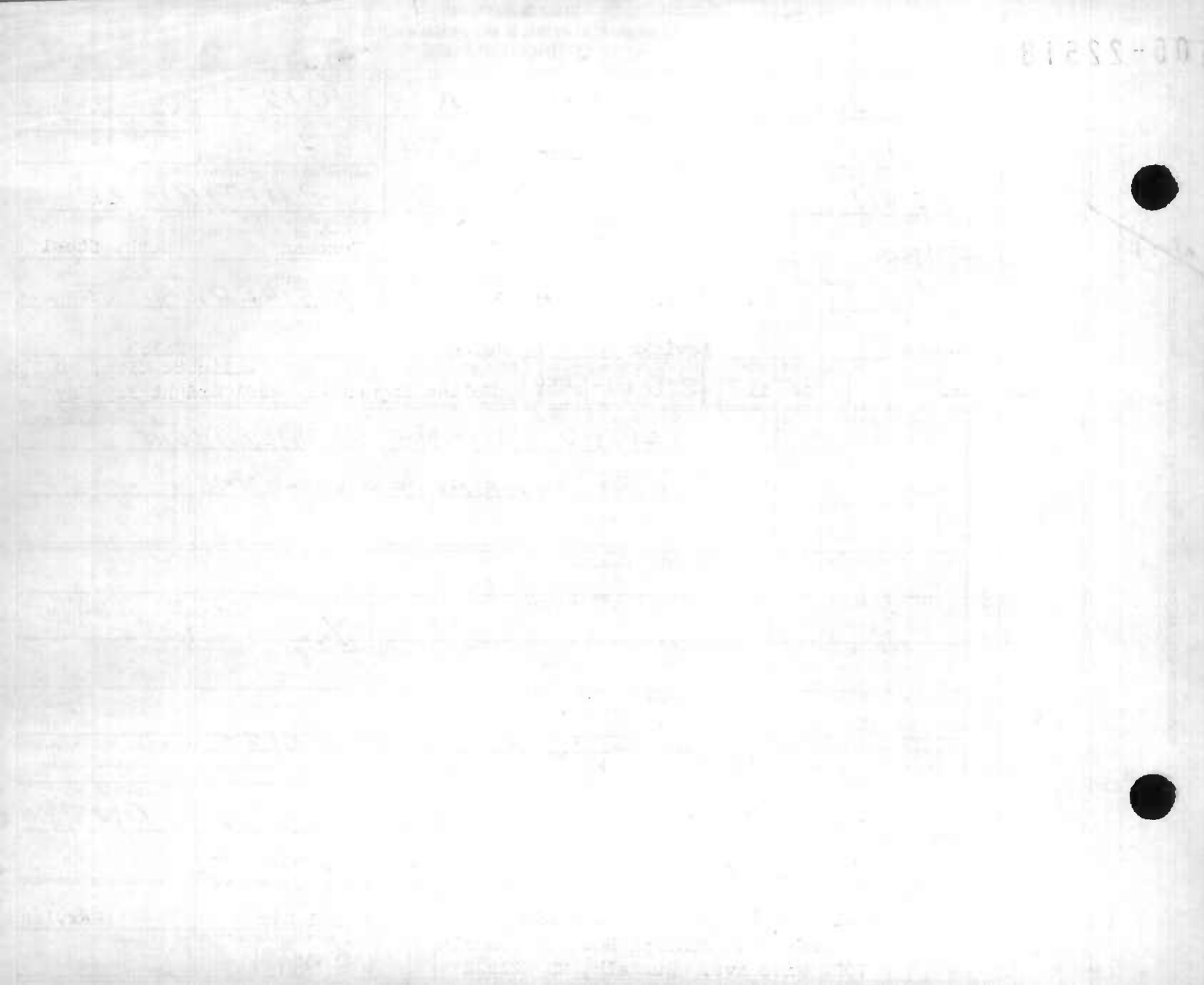
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE      | LAST  | 2a. DATE OF DEATH  | MONTH                    | DAY   | YEAR                              | 2b. HOUR                        |
|---|---|--|-------------|---|--|--------------------------|---|-----------------------------------|---------------------------------|
| JOHN  |   |  |             | LAVINKA   | 10/25/86   |                          |   |                                   | 359 M                           |
| 3. SEX  | M   | 4. RACE  | W           | 5. DATE OF BIRTH  | 02   | MONTH                    | DAY   | YEAR                              | 6. AGE (IN YEARS LAST BIRTHDAY) |
|   |   |  |             | 01/12/19  | 67   |                          |   |                                   | YRS.                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | PENN  | 7b. CITIZEN OF WHAT COUNTRY?   | U.S.        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                          |   |                                   |                                 |
|   |   |  |             |   | BALTIMORE MD.  |                          |   |                                   |                                 |
| 10. CITY OR TOWN OF DEATH   | Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |             |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                          |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                 |
|   |   | FSK HOSPITAL   |             |   | Foreman  |                          |   | Beth. Steel                       |                                 |
| 13a. STATE  | MD  | 13b. COUNTY  | BALTO       | 13c. CITY OR TOWN   | BALTIMORE  | 13d. INSIDE CITY LIMITS? | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS               |                                 |
|   |   |  |             |   |  |                          |   | 2124 7515 BERKSHIRE RD            |                                 |
| 14. FATHER'S NAME   | Thomas  | 15. MOTHER'S MAIDEN NAME   | Helen Valch |   |  |                          |   |                                   |                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | Yes   | 16b. SOCIAL SECURITY NO.   | 220-01-6458 | 17. INFORMANT   | Jolene Szymanski   |                          |   |                                   |                                 |
|   |   |  |             | ADDRESS   | Ellicott City, MD 21043  |                          |   |                                   |                                 |
|   |   |  |             |   | 21043 4201 Bright Bay Way                                      |                          |   |                                   |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  |             |   |  |                          |   |                                   |                                 |
| PART 1. DEATH WAS CAUSED BY:  |   |  |             |   |  |                          |   |                                   |                                 |
| IMMEDIATE CAUSE (a) LIVER FAILURE RENAL FAILURE   |   |  |             |   |  |                          |   |                                   |                                 |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |             |   |  |                          |   |                                   |                                 |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |   |  |             |   |  |                          |   |                                   |                                 |
| (b) HEPATORENAL SYNDROME  |   |  |             |   |  |                          |   |                                   |                                 |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |             |   |  |                          |   |                                   |                                 |
| (c)   |   |  |             |   |  |                          |   |                                   |                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |   |  |             |   |  |                          |   |                                   |                                 |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |             | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                          |   |                                   |                                 |
|   |   |  |             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                          |   |                                   |                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY   |  |             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |                          |   |                                   |                                 |
|   | HOUR A.M. MONTH DAY YEAR  |  |             |   |  |                          |   |                                   |                                 |
|   | P.M. 19   |  |             |   |  |                          |   |                                   |                                 |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |             | 21f. LOCATION   |  |                          |   |                                   |                                 |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |  |             | STREET CITY OR TOWN COUNTY STATE  |  |                          |   |                                   |                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19/86, to 10/25/86, that (I) (we) last saw the deceased alive on 10/25/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |             |   |  |                          |   |                                   |                                 |
| 22b. SIGNATURE  | 22c. DATE SIGNED  |  |             | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                          |   |                                   |                                 |
| JANCZUR   | 10/25/86  |  |             | JANCZUR M.D.  |  |                          |   |                                   |                                 |
|   | 22e. ADDRESS  |  |             | 22f. DATE REC'D. BY REGISTRAR   |  |                          |   |                                   |                                 |
|   | FSK HOSPITAL  |  |             | OCT 29 1986   |  |                          |   |                                   |                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   |             |   | 23d. LOCATION  |                          |   |                                   |                                 |
| Burial  | 10-29-86  | Bel Air  |             |   | Bel Air Maryland   |                          |   |                                   |                                 |
| 24. FUNERAL DIRECTOR  | 25a. DATE REC'D. BY REGISTRAR                                       |  |             | 25b. REGISTRAR'S SIGNATURE  |  |                          |   |                                   |                                 |
| Duda-Ruck Funeral Home of Dundalk   | OCT 29 1986   |  |             | [Signature]   |  |                          |   |                                   |                                 |
| 7922 Wise Ave. Dundalk, MD 21222  |   |  |             |   |  |                          |   |                                   |                                 |





0-21352

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be placed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked "Other", voluntary injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.)

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28368  
REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>EDWIN FRANCIS LEARY</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>13</b> YEAR <b>1986</b>   |  | 2b. HOUR<br><b>12.45 PM</b>  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Sept.</b> DAY <b>18</b> YEAR <b>1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter (ret.)</b>                                   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto. Co.</b>  |  | 13c. CITY OR TOWN<br><b>Rosedale</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Francis</b> MIDDLE <b>M.</b> LAST <b>Leary</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>Taylor</b> LAST <b>Taylor</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Na</b>  |  | 17. INFORMANT (NAME)<br><b>Mrs. Ruth Rehill</b>   |  | ADDRESS<br><b>Same as #13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>gastrointestinal bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 days ± 10 yrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Michael Chait</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10/13/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Chait</b>   |  |   |  | 22e. ADDRESS<br><b>Good Samaritan, 5661 Loch Raven</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Oct. 14, 86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process Inc.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto. Co. MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charlton-Schweiger F.H.</b>  |  |   |  | ADDRESS<br><b>2007 Eastern Ave. Balto.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 15 1986</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |  |  |

BP \_\_\_\_\_

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023703 NOV 13-86

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28507  
REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Thomas M Leatherwood</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 26 86</b>                   |   | 2b. HOUR<br><b>8:00 P.M.</b>                                    |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 21 30</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.<br/>Washington</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial</b>                          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private</b>             |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>P.G.</b> 13c. CITY OR TOWN <b>Capital Hgts</b> 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>13e. STREET ADDRESS / ZIP CODE <b>359 Possum Ct 20743</b> |  |   |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas M. Leatherwood</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Myrtle Harriston</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>579 34 0093</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>359 Possum Ct.<br/>Herma J. Leatherwood Capital Hgts, Md</b> |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Anterior MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>~ 2 hours</b> |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> , 19 <b>86</b> , to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on <b>10/26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Brian H. Kahn, M.D.</b>  |  | DEGREE<br><b>M.D.</b>  | 22c. DATE SIGNED<br><b>10/29/86</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Brian H. Kahn, M.D.</b>   |  | 22e. ADDRESS<br><b>Union Memorial Hosp. 21218</b>                                    |   |

|   |                              |   |   |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>     | 23b. DATE<br><b>10/31/86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Memorial</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland P.G. Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>R.N. Horton Co. Morticians</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1986</b>           |   |
| ADDRESS<br><b>600-Kennedy</b>                                     |                              | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>              |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

1998年12月15日

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8628370  
REG. NO.

1- FOR  
STATE  
REGISTRAR

00-21551

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
*Callunia Lee*

2a. DATE OF DEATH MONTH DAY YEAR  
*10-16-86*

2b. HOUR MIN.  
*0110* M.

3. SEX *F*

4. RACE *B*

5. DATE OF BIRTH MONTH DAY YEAR  
*3 9 1928*

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS  
*58*

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
*S.C.*

7b. CITIZEN OF WHAT COUNTRY?  
*U.S.A.*

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
*City* MD.

10. CITY OR TOWN OF DEATH  
*Balto.*

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
*Sinai Hospital*

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
*Domestic*

12b. KIND OF BUSINESS OR INDUSTRY  
*Home.*

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE  
*Md. Balto. YES 5102 Wesley Ave. 21207*

14. FATHER'S NAME FIRST MIDDLE LAST  
*William Dean*

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
*Hattie Dean*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
*No*

16b. SOCIAL SECURITY NO.  
*217-22-1173*

17. INFORMANT ADDRESS  
*Mr. Benson Lee 5102 Wesley Ave. 21207*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Cardiac Arrest*  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) *hypotension*  
DUE TO, OR AS A CONSEQUENCE OF (c) *cardiac vessel collapsed & blood loss*  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
*20 min.*  
*4 hrs*  
*10 hrs*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: *Colon Carcinoma with diff. Abd. mets*

19a. DATE OF OPERATION  
*10-15-86*

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
*see above*

20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
*OR CONTRIBUTING*

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
*P.M. 19*

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that (I) (we) lost saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
*C.D. Stone*

DEGREE  
*MD*

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED  
*10/16*

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
*C.D. Stone*

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
*Burial*

23b. DATE  
*10-21-86*

23c. NAME OF CEMETERY OR CREMATORY  
*Cedar Hill Cem.*

23d. LOCATION CITY OR TOWN COUNTY STATE  
*Balto. Md.*

24. FUNERAL DIRECTOR NAME ADDRESS  
*Gas. A. Morton & Sons 1701 Laurens*

25a. DATE REC'D. BY REGISTRAR  
*OCT 20 1986*

25b. REGISTRAR'S SIGNATURE  
*John Benson*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



00-2134

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 2 8 3 7 1

|   |  |   |   |   |  |  |   |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Helen J. Leuba</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-13-86</b>                        |   |  | 2b. HOUR PM<br><b>5:30</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-21-1926</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                       |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5110 Richard Ave.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5110 Richard Ave. 21214</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Kelly</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mae Silberzahn</b>        |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-10-3620</b> |   | 17. INFORMANT ADDRESS<br><b>Elie E. Leuba, Sr., Same as 13e</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs.</u> |  |   |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> 19 <u>83</u> to <u>10-13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10-13</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Jaime Punzalan</u>   |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><u>10/16/86</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jaime Punzalan, M.D.</b>  |  |   |   |   | 22e. ADDRESS<br><b>5214 Harford Rd.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>10-17-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John A. ...</u>  |  |  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2:30 PM

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00-21211

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8028372

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | MONTH DAY YEAR  |  |
| ETTA   |  | LEVIN  |  | OCTOBER 12, 1986  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| FEMALE   |  | WHITE  |  | MONTH DAY YEAR  |  |
|  |  |  |  | SEPT. 12, 1904  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |
| 82 YRS.  |  | MARYLAND   |  | USA   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. CITY OR TOWN OF DEATH   |  |
|  |  | BALTIMORE CITY   |  | BALTIMORE   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| MARYLAND GENERAL HOSPITAL  |  | RETIRED TYPIST   |  | CITY HEALTH DEPT.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| MARYLAND   |  | BALTIMORE  |  | BALTIMORE   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  | NO  |  |
| ISAAC A. LEVIN   |  | RAE RACHEL GOODMAN   |  | 16b. SOCIAL SECURITY NO.  |  |
|  |  |  |  | 214-40-5910   |  |
| 17. INFORMANT  |  | ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |
| SHELDON BUCKNER  |  | 808 WOODGLEN PL. #21208  |  | PART 1. DEATH WAS CAUSED BY:  |  |
|  |  |  |  | IMMEDIATE CAUSE (a) Probable Myocardial Infarction  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |
|  |  |  |  | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |
|  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:            |  |
|  |  |  |  | (1) Gangrene part of small bowel (2) Aspiration   |  |
| 9a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
| October 12, 1986   |  | Abdominal pain, Questionable Sepsis  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
|  |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from   |  | October 10, 1986   |  | to October 12, 1986 that (we) last saw the deceased alive on  |  |
|  |  | October 12, 1986   |  | and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| Thomas H. Ganey  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 10/13/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |
| Thomas H. Ganey  |  | c/o Maryland General Hospital  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| BURIAL   |  | OCT. 14, 1986  |  | BNAI ISRAEL   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. DATE REC'D BY REGISTRAR   |  | 24c. REGISTRAR'S SIGNATURE  |  |
| SOL LEVINSON & BROS., INC.   |  | OCT 16 1986  |  | Julia Levinson-Rodarte  |  |
| 6010 REISTERSTOWN RD. BALTO, MD 21215  |  |  |  |   |  |

MEDICAL CERTIFICATION

BP 15

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-5-00

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00-20259

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28313

|   |  |   |  |  |
|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FREDERICK PHILLIP LEVIN</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 1 86</b>   |  | 2b. HOUR<br><b>8:30 AM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 24, 1937</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                    |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKS SCOTT KEY Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b>      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OFFICE EQUIP.</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>RANDALLSTOWN</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD LEVIN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RUTH BRONSTEIN</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-5228</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. ILEAN LEVIN</b><br><b>3941 BRYONY RD. RANDALLSTOWN, MD 21133</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |
| 22a. I certify that (1) this hospital attended the deceased from <b>10/1</b> , 19 <b>86</b> , to <b>10/1</b> , 19 <b>86</b> that (we) last saw the deceased alive on <b>10/1</b> , 19 <b>86</b> , and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.                     |  |   |  |  |
| 22b. SIGNATURE<br><b>Ethan Dubin MD</b>   |  | 22c. DATE SIGNED<br><b>10/1/86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ethan Dubin</b>   |  | 22e. ADDRESS<br><b>4940 Eastern Ave Baltimore Md</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>OCT. 3, 1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOSES MONTEFIORE WOODMOOR HEBREW BALTIMORE MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 08 1986</b>   |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 indicates any injury, or other traumatic event, no medical examiner will be notified at this time.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



0-20275

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28374

|   |  |   |   |   |  |   |  |   |   |  |
|---|--|---|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PEARL F LEWINN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>OCT</b> DAY <b>1</b> YEAR <b>86</b>           |   |  | 2b. HOUR<br><b>1422</b>   |  |   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Cauc</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>SEP</b> DAY <b>13</b> YEAR <b>07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AUTHOR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LITERATURE</b>  |   |  |
| 13a. STATE<br><b>PA</b>   |  |   | 13b. COUNTY<br><b>BUCKS</b>   |   | 13c. CITY OR TOWN<br><b>UPPER BLACK</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>RD 1 Box 439 #18972</b>         |  |
| 14. FATHER'S NAME<br>FIRST <b>MORRIS</b> MIDDLE <b>FREEDMAN</b> LAST <b>EDDY</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>BELLA</b> MIDDLE <b>RYNES</b>          |   |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)  |  |   | 16b. SOCIAL SECURITY NO.<br><b>186367340</b>                                |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. MARGERY DOROSHOW</b><br><b>7902 GWARA BALTO., MD 21208</b> |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPOXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PNEUMONIA</b>  |  |   |   |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>OCT 1, 1986</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>OPEN Lung Biopsy</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>a) WORK b) AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 1</b> 19 <b>86</b> , to <b>OCT 1</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>OCT 1</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>H. Madden</b> MD   |  |   |   |   |  | 22c. DATE SIGNED<br><b>10/1/86</b>  |  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. MADDEN</b> |  |
| 22e. ADDRESS<br><b>BELVEDERE GREENSPRING</b>  |  |   |   |   |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>CREMATION</b>   |  |   | 23b. DATE<br><b>OCT 3, 1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                                       |   | 23d. LOCATION<br><b>BALTIMORE</b> COUNTY <b>MARYLAND</b>                             |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 8 1986</b>                                |  | 25b. REGISTRAR'S SIGNATURE  |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP  
DHMH - 16 50M / 1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. <b>28375</b>   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERT LEWIS</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 4, 86</b>  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 16 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>85</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>907 N. CHESTER ST.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BAITIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>907 N. CHESTER ST. 21205</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT LEWIS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LDA WITHERS</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>224-14-5866</b>  |  | 17. INFORMANT<br><b>BEATRICE LEWIS</b>  |  | ADDRESS<br><b>907 N. CHESTER</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CANCER OF THE PROSTATE WITH WIDESPREAD BONE METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 16, 1986</b> to <b>1986</b> , that (I) (we) lost saw the deceased alive on <b>1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>L. M. JUMANOY, M.D.</b>  |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/6/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. M. JUMANOY, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>100 N. BROADWAY, BALTO. MD. 21231</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-10-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNE ARUNDEL MARYLAND</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>MARCH FUNERAL HOMES 1101 E. NORTH AVE.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 09 1986</b>  |  |  |  |



25386



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 86 28376

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Alphonso F. Lewis  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 22, 1986                        |   | 2b. HOUR<br>M  |
| 3. SEX<br>Male  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 15 21   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY. MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>206 N. MONASTERY AVENUE |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A        |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Lewis   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ada Ford                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-05-3431  | 17. INFORMANT<br>ADDRESS<br>Mateil Collins 206 N. Monastery Avenue             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Lung CA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 85</u> to <u>Oct 86</u> , that <u>0</u> (we) last saw the deceased alive <u>Oct 86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <u>0</u> (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Bulent Atac</u>  |  | DEGREE<br>MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  | 22c. DATE SIGNED<br><u>Oct 23, 86</u>                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Bulent Atac</u>   |  | 22e. ADDRESS<br><u>St. Agnes Hosp. 900 Caton Ave</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   | 23b. DATE<br>10/27/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills, Md.           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MARCH FUNERAL HOMES 1101 East North Avenue  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1986  |  | 25b. REGISTRAR'S SIGNATURE  |  |

MEDICAL CERTIFICATION

99

BP



2  
10-22423

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove certain portions and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 1 DECEASED NAME (TYPE OR PRINT)<br>KING SOLOMON LEWIS  |  |   |  | 2a DATE OF DEATH<br>10 25 86   |  | 2b HOUR<br>M  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Black  |  | 5 DATE OF BIRTH<br>5 1 14   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS   |  | 7 IF UNDER 1 YEAR MONTHS DAYS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2610 Park Heights TERR. |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                        |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br>Md.  |  | 13b COUNTY   |  | 13c CITY OR TOWN<br>Balto.  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br>2610 Park Hgts Terr 21215  |  |
| 14 FATHER'S NAME<br>King S. Lewis   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>Marion Tunstle   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>231-27-2728   |  | 17 INFORMANT ADDRESS<br>Marie Jones 2610 Park Hgts Terr   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ISCHEMIC HT. DIS.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |  |  |  |   |  |  |  |   |  |
| MEDICAL CERTIFICATION   |  |  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 8/23/86 to 10/25/86, that (I) (we) lost saw the deceased alive on 9/21/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b SIGNATURE<br>J. BRAXTON   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                            |  |  |  | 22c DATE SIGNED<br>10/27/86   |  |
| 22d PHYSICIAN'S NAME (OR PRINT)<br>J. BRAXTON   |  | 22e ADDRESS<br>4432 PARK HTS. AVE. BALTO., MD, 21215   |  |   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>10/31/86   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Metropolitan Baptist Church  |  | 23d LOCATION<br>Middlesex  |  | COUNTY STATE<br>Va  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H West  |  |  |  | ADDRESS<br>4300 Wabash Ave  |  | 25a DATE REC'D. BY REGISTRAR<br>OCT 29 1986  |  | 25b REGISTRAR'S SIGNATURE   |  |



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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.

2 8 3 1 8

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>OLIVER LEWIS  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-6-86 |   |  | 2b. HOUR<br>5:00 A.M.  |  |
| 3. SEX<br>M  |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 01 42   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>42 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br>Smith, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OR DEATH<br>Baltimore MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Smith.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Liberty Medical Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Laborer   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>Smith.   |  | 13c. CITY OR TOWN<br>Smith.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Lewis  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>George Wilson  |  | 16. SOCIAL SECURITY NO.<br>219-40-0112  |  |  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 17b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-40-0112  |  | 17c. INFORMANT<br>Address<br>Mary Lewis - 2023 N. 2nd St. #8  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiomyopathy + Tamponade</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Renal Failure - Liver Failure - Sepsis - Resp. failure.</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-26</u> 19 <u>86</u> , to <u>10-6</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Bich T Duong, MD</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>10-6-86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BICH T DUONG  |  |   |  | 22e. ADDRESS<br>730 Ashburton St Baltimore, Md 21216  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE<br>10/11/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Smith. U.S.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lorain Carroll   |  |   |  | ADDRESS<br>1712 W. North Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 08 1986   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and a registered nurse or other qualified person within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a registered nurse or other qualified person, it should be detached for use as the burial-transit permit. Then please give the permit to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-20382



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and indented in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |                                |  |  |
|--|--|--|--|--|--|--|--------------------------------|--|--|
| 1 - FOR STATE REGISTRAR <i>Item 13a-e</i><br><i>10-22-86 CW Phone</i>  |  |  |  |  |  |  |                                |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH LEWIS</b>  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 17, 1986</b> |  | 2b HOUR P M<br><b>5:11 P M</b> |  |  |
| 3 SEX<br><b>M</b>  |  | 4 RACE<br><b>Col 2</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>17 95</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>91</b>                                 |                                | 7 IF UNDER 1 YEAR MONTHS DAYS<br># UNDER 24 HRS. HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                 |                                |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Va</b> CITY <b>Hon</b> COUNTY <b>Portsmouth</b>  |  | 13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13c STREET ADDRESS ZIP CODE<br><b>2107 Watts Rd VA. 99999-2870</b>   |  |  |                                |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles Lewis</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sarah Mosley</b>   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b SOCIAL SECURITY NO.<br><b>217-07-1351</b>                                    |                                | 17 INFORMANT ADDRESS<br><b>Charles Lewis 2049 Bentalon Rd 21216</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA</b>  |  |  |  |  |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b><br><b>2 days</b><br><b>7 days</b>                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |                                |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                |  |  |
| 21d INJURY OCCURRED (a) HOME <input type="checkbox"/> (b) NOT HOME <input type="checkbox"/> (c) AT WORK <input type="checkbox"/> (d) AT SCHOOL <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                                |  |  |
| 22a I certify that, (I) (this hospital) attended the deceased from <b>8/8/86</b> to <b>10/17/86</b> , that (I) (we) lost saw the deceased alive on <b>10/17/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) |  |  |  |  |  |  |                                |  |  |
| 22b SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |  |                                | 22c DATE SIGNED<br><b>10.17.86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLTON WILSON MD</b>  |  | 22e ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |  |  |  |                                |  |  |
| 23a BURIAL, CREMATION, REMOVAL (TYPE)<br><b>Burial</b>   |  | 23b DATE<br><b>10-21-86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Arbuthnot Park</b>   |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Balt. Co. Md.</b>                   |                                |  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Joseph L. Russ</b>  |  | ADDRESS<br><b>2222 N. North Ave</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>OCT 21 1986</b>   |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                  |                                |  |  |

MEDICAL CERTIFICATION

RECEIVED FOR THE DIRECTOR



12/12/20



Item # 5, Film G621, 11.28.86 ra

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28380

1- STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |   |                                   |                                   |  |
|---|--|---|---|---|--|---|--|---|-----------------------------------|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William P Lewis                      |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 24 86 |   |  | 2b. HOUR<br>4:45 PM   |  |   |                                   |                                   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 10 1921  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                       |                                   | 7. IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |                                   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Liberty Medical Center (Guthrie) |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                   |  |
| 13a. STATE<br>Md  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS, ZIP CODE<br>2518 Shirley Ave 21215 |                                   |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Patrick H. Lewis                  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dessie Frye  |  |   |  |   |                                   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-18-6647  |  | 17. INFORMANT<br>Edith E. Lewis   |  |   |                                   | ADDRESS<br>2518 Shirley Ave       |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c) Left Lung Pneumonia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Aortic Aneurysm, Thoracic Aortic Aneurysm, Renal Failure, Gastrointestinal Hemorrhage

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 10/1/86 to 10/24/86, that (b) (we) last saw the deceased alive on 10/24/86, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (c) (we/our) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Darrell M. Gray, M.D.   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 17c. DATE SIGNED<br>10/24/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Darrell M. Gray, M.D.  |  | 22e. ADDRESS<br>2329 Arundel Avenue Baltimore, Md 21216                |  |  |  |  |  |

|  |  |                       |  |   |  |   |  |
|--|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                     |  | 23b. DATE<br>10/29/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Vet |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills Md |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1986              |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, the medical examiner's report should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's report should be attached to this certificate.

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EXHIBIT NO. 100-100-00



EXHIBIT NO. 100-100-00

EXHIBIT NO. 100-100-00

EXHIBIT NO. 100-100-00

EXHIBIT NO. 100-100-00

EXHIBIT NO. 100-100-00

EXHIBIT NO. 100-100-00

EXHIBIT NO. 100-100-00

00-21446

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (15))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | REG. NO. 2 8 3 8 1   |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>STRUTHER E. LIGHTMAN  |  |  |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10-10-86 <sup>19</sup> |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUC.                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 14 1914   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>73 YRS.   |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.               |  | 2c. DATE PRONOUNCED DEAD<br>10-10-86 <sup>19</sup> 1:15P                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MISC.   |  |
| 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY                            |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>6703 GARY AVENUE 21222                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWARD LIGHTMAN  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOLA ?  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |  |  | 16b. SOCIAL SECURITY NO.<br>WW II 213-01-6911  |  | 17. INFORMANT ADDRESS<br>Mrs. Shirley Lightman - 6703 Gary Ave. 21222   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.  |  |  |  | TITLE (SPECIFY)<br>Assistant   |  |   |  | DATE SIGNED<br>10-10-86  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |  |  |  | ADDRESS<br>111 Penn Street   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  | 23b. DATE<br>10/13/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MORELAND MEMORIAL   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD.             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER DABROWSKI - 1005 DUNDALK AVENUE 21224   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1986  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

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00-21448

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 3 8 2  
REG. NO.

|  |  |   |  |
|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Bernard L. LINGERMANN JR.</i>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR HOUR<br><i>10 16 86 0530M</i>   |  |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>May 25, 1899</i>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Agnes Hospital</i> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Printer</i>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Book</i>   |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   | 13c. CITY OR TOWN<br><i>Catonsville</i>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Bernard LINGERMANN Sr.</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Josephine Ware</i>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>216-05-5963</i>  | 17. INFORMANT<br><i>Helen LINGERMANN</i>   |
|  |  | ADDRESS<br><i>Same as # 13</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Renal failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Carcinoma Prostate</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) not view the body after death.   |  |   |  |
| 22b. SIGNATURE<br><i>Latha R. Pillai</i>   |  | DEGREE<br><i>MD</i>   | 22c. DATE SIGNED<br><i>10/16/86</i>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>PILLAI, LATHA</i>  |  | 22e. ADDRESS<br><i>St Agnes Hospital</i><br><i>Baltimore, MD.</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i>   | 23b. DATE<br><i>10/17/86</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview Crematory</i>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Catonsville Maryland</i>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.<br/>1630 Edmondson Avenue, Catonsville, MD. 21228</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 17 1986</i>   | 25b. REGISTRAR'S SIGNATURE<br><i>John Edmondson</i>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side. The text is too light to transcribe accurately.]

00-22535

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 8 3 8 3

|   |   |   |   |   |   |  |   |  |
|---|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH   |   |   | 2b. HOUR                                   |   |  |
| FIRST MIDDLE LAST<br>Jacqueline J. LINSSENMEYER   |   |   | MONTH DAY YEAR<br>10/25/86  |   |   | 10 <sup>14</sup> P.M.                      |   |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |   | 6. AGE  |   | 7. IF UNDER 1 YEAR                         |   | 8. IF UNDER 24 HRS.                          |
| F   | Cauc  | MONTH DAY YEAR<br>Mar. 21 29  |   | 57 YRS  |   | MONTHS DAYS                                |   | HOURS MIN.                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |  |   |  |
| Rhode Island  | USA   |   |   | CITY MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore   | South Baltimore Gen. Hosp.  |   |   | Collection Off.   |   |  | Bank  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |   |   |  |   |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE  |   |  |   |  |
| MD  | Balt  | Parkville   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1700 Glen Keith Blvd 21229  |   |  |   |  |
| 14. FATHER'S NAME   |   |   | 15. MOTHER'S MAIDEN NAME  |   |   |  |   |  |
| FIRST MIDDLE LAST<br>Francis Sattur   |   |   | FIRST MIDDLE LAST<br>Agnes Powers                                   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |  |   |  |
| No  |   |   | 020209593   |   | Barry Linsenmeyer, 101 Riverbed La., S.C.                           |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |   |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |   |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |   |  |   |  |
|   |   |   |   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.                                 |   |   |   |   |   |  |   |  |
| 22b. SIGNATURE  |   |   | DEGREE  |   |   | 22c. DATE SIGNED                           |   |  |
| John Tretter  |   |   |   |   |   | 10/25/86                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |   | 22e. ADDRESS  |   |   |  |   |  |
| John Tretter  |   |   | 3001 S. Hanover St.   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |  |
| Cremation   |   | 10/29/86  |   | Security Process Crem.  |   | CATonsville Balto. Md.                     |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |   |   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                 |   |  |
| Hubbard Funeral Home, Inc.,   |   |   |   | 21229 4107 Wilkens Ave.   |   | OCT 29 1986                                |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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00-21984

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 2a DATE OF DEATH  |  | 2b HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>XXXXXXX TOBY</b>  |  | MONTH DAY YEAR <b>10/19/86</b>  |  | 8:10 P.M.   |  |
| 3 SEX <b>Female</b>   | 4 RACE <b>CAUCASIAN</b>  | 5. DATE OF BIRTH <b>APRIL 1, 1887</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>99</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>XXXXXXX RUSSIA</b>  | 7b CITIZEN OF WHAT COUNTRY? <b>US A.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Revindale</b> |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PROPRIETOR</b> |   | 12b KIND OF BUSINESS OR INDUSTRY <b>CONFECTIONARY RETAIL</b>   |
| 13a STATE <b>MARYLAND</b>   |  | 13b COUNTY <b>BALTO.</b>  | 13c CITY OR TOWN <b>BALTIMORE</b>  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME (FIRST MIDDLE LAST) <b>MAISHE YOUSEM</b>   |  | 15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>ZIVIE SUTTLEMAN</b>  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b SOCIAL SECURITY NO. <b>216-50-1774</b>  |  | 17 INFORMANT ADDRESS (21209) <b>MRS. ESTHER SCHOEN 6646 SANZO RD., APT. C</b>               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b>   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION (CITY OR TOWN COUNTY STATE)  |  |
| 22a I certify that (this hospital) attended the deceased from <b>12/23</b> 19 <b>86</b> to <b>10/19</b> 19 <b>86</b> , that (we) last saw the deceased alive on <b>10/19</b> 19 <b>86</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. |  |   |  |   |  |
| 22b SIGNATURE <b>Estrelita O. Kn</b>  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED <b>10/20/86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELITA O. Kn</b>   |  | 22e ADDRESS <b>LEVINDAVE HEBREW GERIATRIC CENTER - HARTFORD</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b DATE <b>10/20/86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY <b>RODDE ZEDEK CEM</b>                                    |  |
| 23d LOCATION (CITY OR TOWN COUNTY STATE) <b>BALTIMORE MD</b>  |  | 24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>  |  |   |  |
| 24b ADDRESS <b>6010 REISTERSTOWN RD. BALTO, MD 21215</b>  |  | 25a DATE REC'D. BY REGISTRAR <b>OCT 23 1986</b>   |  | 25b REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

48015-00

20% COTTON FIBER



00-224171

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28585

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEROY H. LIST</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 27, 1986</b>                             |   | 2b. HOUR<br><b>8:30 PM</b>   |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 27, 1917</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MARYLAND GENERAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Attorney at Law</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Kingsville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John H. List</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara Anna Qundina</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 212-28-3918</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth M. List 11501 Cedar Lane 21087</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC LIVER ADENOCARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (if in this hospital) attended the deceased from <b>October 27, 1986</b> to <b>October 27, 1986</b> , that (X) (we) last saw the deceased alive on <b>October 27, 1986</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) (not) view the body after death.                   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Henry Mammour</b>  |   |   |  | 22c. DATE SIGNED<br><b>10-28-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HENRY NAMMOUR M.D.</b>  |   |   |  | 22e. ADDRESS<br><b>c/o MARYLAND GENERAL HOSPITAL</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>Oct 31 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Salem United Meth. Ch.</b>                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Upper Falls Maryland</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1986</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>  |   | 25a. ADDRESS<br><b>Baltimore, Maryland</b>  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "other", the medical examiner must be notified at once.

BP

00-22412

of  
Maryland

U.S.A.

Maryland

Don

Ken

M.

II

219-28-2118

Charm

1985

Anna

1101 Cedar Lane 21037

1101 Cedar Lane 21037



Robert J. Hook, Inc. Baltimore, Maryland

1001 21001 Cedar Lane 21037

00-20376

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. ATTACHED TO THIS CERTIFICATE IS A PENCIL COPY OF THE FUNERAL DIRECTOR'S REPORT. THIS REPORT, ALONG WITH FORM FM 3, RETAIN IN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORTATION REPORT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28580

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |   |  |  |  |   |  |
|--|---------|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH  |  | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |  | 2b. HOUR  |  |
| ROBERT   |         | H.   |  | LITTLE  |  | Jr.   |  | 10-4-86   |  | 19   |  | M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS   |  | 7c. DATE<br>PRONOUNCED<br>DEAD   |  | 7d. HOUR  |  |
| M  | B       | 6 13 44  |  | 42 YRS.   |  | MONTHS DAYS HOURS MIN.  |  |   |  | 10-4-86  |  | 19 3:08A  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |  |  |   |  |
| Maryland   |         | U.s.a.   |  |   |  | Baltimore City  |  |   |  |  |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |   |  |  |  |   |  |
| Baltimore  |         | University Hospital  |  | N/A   |  |   |  |   |  |  |  |   |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |  |  |   |  |
| Maryland   |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 111 North Carey Street 21223  |  |  |  |   |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |  |  |  |   |  |
| Robert   |         | Pora   |  | H.  |  | Little Sr.  |  | McLeod  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |  |  |   |  |
| No   |         | 216422022  |  | Pora Mc Leod  |  | 111 North Carey Street  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 1 DEATH WAS CAUSED BY:  |         |  |  |   |  |   |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>Thoracic trauma</u>   |         |  |  |   |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last   |         |  |  |   |  |   |  |   |  |  |  |   |  |
| (b) _____  |         |  |  |   |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |  |  |   |  |
| (c) _____  |         |  |  |   |  |   |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |   |  |   |  |   |  |  |  |   |  |
| <u>hypertensive cardiovascular disease and pleural adhesions</u>   |         |  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?   |  |   |  |
|  |         |  |  |   |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:35A 10-4-86 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |
|  |         |  |  |   |  |   |  | pedestrian struck by a motorvehicle   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |         |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION   |  |  |  |   |  |
|  |         |  |  | street  |  |   |  | Southbound 395 South of Balto., Maryland                                      |  |  |  |   |  |
|  |         |  |  |   |  |   |  | Conway  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL<br>SIGNATURE  |         |  |  | TITLE (SPECIFY)   |  |   |  |   |  | DATE<br>SIGNED   |  |   |  |
|  |         |  |  | Deputy Chief  |  |   |  |   |  | 10-4-86  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  |  | ADDRESS   |  |   |  |   |  |  |  |   |  |
| Ann M. Dixon, M.D.   |         |  |  | 111 Penn Street   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |   |  | 23d. LOCATION  |  |   |  |
| Burial   |         |  |  | 10/9/86   |  | Mount Auburn  |  |   |  | Baltimore  |  |   |  |
|  |         |  |  |   |  |   |  |   |  | COUNTY STATE   |  |   |  |
|  |         |  |  |   |  |   |  |   |  | Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR   |         |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Wm. C. March Funeral Home Inc. 1101 East North Ave   |         |  |  |   |  | OCT 08 1986   |  |   |  |  |  |   |  |

21602-00

00-21926

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

| FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 23581  |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Mary Eileen Lochary</i>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10 20 86</i>  |  | 2b. HOUR<br><i>14:45 PM</i>   |  |
| 3 SEX<br><i>FEMALE</i>  | 4 RACE<br><i>WHITE</i>   | 5 DATE OF BIRTH MONTH DAY YEAR<br><i>12 - 18 - 1914</i>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>71</i> YRS.                                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>   | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i> MD.                            |   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Agnes Hospital</i> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Claims Rep.</i> | 12b KIND OF BUSINESS OR INDUSTRY<br><i>Social Security</i>  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Woodlawn</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Hugh Mc Mahan</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Anne Selheimer</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>                                      |  |
| 16b. SOCIAL SECURITY NO.<br><i>219-10-8694</i>  |  | 17 INFORMANT ADDRESS<br><i>Donald Lochary - 400 Allview Ct. 21228 Catonsville, MD.</i>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>small cell Ca. of the lung</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>multiple cerebral infarction</i>   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)         |  |   |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/20</i> 19 <i>86</i> to <i>10/20</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>10/20</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Monroe Lee</i>   |  | DEGREE   |  | 22c. DATE SIGNED<br><i>10/20/86</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Lee, Monroe</i>   |  | 22e. ADDRESS<br><i>St. Agnes Hospital, Baltimore MD</i>  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>   |  | 23b. DATE<br><i>10-24-1986</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview Crematory</i>   |  |
| 23d. LOCATION / CITY OR TOWN<br><i>Catonsville</i>  |  | COUNTY<br><i>Baltimore</i>   |  | STATE<br><i>MD.</i>   |  |
| 24. FUNERAL DIRECTOR<br><i>Lero &amp; Russell C. Witzke</i>   |  | ADDRESS<br><i>1630 Edmondson Ave., Catonsville, MD. 21228</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 22 1986</i>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>  |  |  |  |   |  |

BP





00-22359

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28688

1 - FOR  
STATE  
REGISTRAR

|  |  |  |                          |   |  |  |                            |  |  |
|--|--|--|--------------------------|---|--|--|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |                          | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |                            | 2b. HOUR   |  |
| Charles  |  | Hogelman   |                          | 10  |  | 15   |                            | 86 12:55   |  |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                            | 7. IF UNDER 1 YEAR   |  |
| M  |  | W  |                          | MONTH DAY YEAR  |  | 6 6  |                            | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                            |  |  |
| Maryland   |  | U.S.   |                          |   |  | Balto. City MD   |                            |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                            | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Balto.   |  | Liberty Medical Center   |                          |   |  | Worker   |                            | Lumber   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |                          |   |  |  |                            |  |  |
| 13a. STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| Md.  |  |  |                          | Balto.  |  |  |                            | 3313 Poplar St. 21216  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |                          |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST         |  |                            |  |  |
|  |  |  |                          |   |  |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT ADDRESS                              |  |                            |  |  |
| Unkn.  |  |  | 220-03-5812              |   | 204 S. Register St. Ms. Betty Williams Balto., Md. |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |                          |   |  |  |                            |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |                          |   |  |  |                            |  |  |
| IMMEDIATE CAUSE (a) SMALL CELL CA WITH DIFFUSE   |  |  |                          |   |  |  |                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |   |  |  |                            |  |  |
| (b) METS TO LIVER  |  |  |                          |   |  |  |                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |   |  |  |                            |  |  |
| (c) GI BLEED, HYPOTENSION  |  |  |                          |   |  |  |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |                          |   |  |  |                            |  |  |
| DIMENTIA   |  |  |                          |   |  |  |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |   |  | 20a. AUTOPSY?  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |                          |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                            |  |  |
|  |  | P.M. 19  |                          |   |  |  |                            |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                            |  |  |
|  |  |  |                          |   |  |  |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/13/86 to 10/15/86, that (I) (we) last saw the deceased alive on 10/15/86, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |   |  |  |                            |  |  |
| 22b. SIGNATURE Ambacher Woreta, MD DEGREE  |  |  |                          |   |  |  |                            | 22c. DATE SIGNED 10/15/86                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHER WORETA  |  |  |                          |   |  |  |                            | 22e. ADDRESS LIBERTY MEDICAL CENTER                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |                            |  |  |
| Removal  |  | 10-19-86   |                          |   |  |  |                            |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |  |                          |   | 25a. DATE RECEIVED BY REGISTRAR                    |  | 25b. REGISTRAR'S SIGNATURE |  |  |
| Anatomy Board Balto., Md.  |  |  |                          |   | OCT 27 1986  |  | Julia D. ...               |  |  |

BP

CHIEF IN CHARGE

20% CO. 12. 11. 11.

0-22698

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |                              |  |  |
|--|--|--|--|---|--|---|------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 28567   |  |   |  |   |                              |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Joseph Logan   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 23 86               |   |                              | 2b. HOUR<br>324p M   |  |
| 3. SEX<br>M  |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>02 03 40   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.  |                              | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt City. MD.  |                              |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balt City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hosp |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Amtrack                        |                              | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET ADDRESS<br>3538 Lynnhaven Dr.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Logan Sr.  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eular B. Lee |   |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>217345666   |  | 17. INFORMANT ADDRESS<br>Marie Randall 5251 Cordelia Ave.                                       |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  |  |  |  |   |  |   |                              |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |   |                              |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |                              |  |  |
| 22b. SIGNATURE<br>Dennis Kurgansky   |  |  |  |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>10-23-86 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dennis Kurgansky  |  |  |  |   | 22e. ADDRESS<br>301 St Paul P Balto MD 21203               |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11-1-86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Md.  |                              |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Leroy O. Dyett  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>10 1986                   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |

Handwritten notes and signatures on lined paper, including a large signature in the center and various smaller markings and text throughout the page.

00-22117

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 8 3 9 0

|  |  |  |  |   |   |   |   |  |  |  |  |
|--|--|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Samuel J. Longo</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>23</b> YEAR <b>1986</b>    |   |   | 2b. HOUR<br><b>9:02</b> M   |   |  |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>March</b> DAY <b>16</b> YEAR <b>1917</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. - Revere Copper &amp; Brass</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Maryland</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6212 Tramore Rd. 21214</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Joseph</b> MIDDLE <b>Longo</b> LAST <b>Longo</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Padovano</b> LAST <b>Padovano</b>   |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 213-05-6417</b>  |   | 17. INFORMANT<br>ADDRESS <b>Mrs. Michalena E. Longo Same as #13e</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>undetermined</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 hours</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1983</b> to <b>Oct 23 1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>Oct 23 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Marc D. Sokolow MD</b>  |  |  |  |   |   | DEGREE <b>MD</b>  |   |  | 22c. DATE SIGNED<br><b>10/23/86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marc D. Sokolow, M.D.</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>333 St. Paul Place Baltimore</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |  | 23b. DATE<br><b>10-27-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                    |   |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY <b>21202</b> STATE |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck, Inc. Baltimore, Md.</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1986</b>  |   |  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed with the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the certificate must be certified by one.



00-22730

DIVISION OF VITAL RECORDS, 201 W. PIERCE ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PIERCE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 8 3 9 1

|   |                  |   |   |   |  |
|---|------------------|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST JACKIE<br>MIDDLE<br>LAST Lovelist  |                  |   | 2a. DATE OF DEATH<br>KNOWN OF ESTI-<br>MATED<br>MONTH 10<br>DAY 27<br>YEAR 1986<br>HOUR 2:45<br>P.M.  |   |  |
| 3. SEX<br>Male  | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH 1<br>DAY 16<br>YEAR 1955                      | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>31 YRS.   | 7. IF UNDER 1 YR.<br>MONTHS<br>DAYS   | 8. IF UNDER 24 HRS.<br>HOURS<br>MIN.   |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina  |                  |   | 10. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 12. CITY OR TOWN OF DEATH<br>Baltimore  |                  |   | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital                |   | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Baltimore City   |
| 15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>3a. STATE MARYLAND<br>13b. COUNTY<br>13c. CITY OR TOWN<br>Baltimore   |                  |   | 16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>17. STREET ADDRESS<br>6116 Macbeth Dr. 21239 |   |  |
| 18. FATHER'S NAME<br>FIRST DENNIS<br>MIDDLE<br>LAST Lovelist  |                  |   | 19. MOTHER'S MAIDEN NAME<br>FIRST HAZEL<br>MIDDLE<br>LAST Young   |   |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |                  |   | 21. SOCIAL SECURITY NO.<br>22. INFORMANT<br>Acqueline Lovelist 6116 Macbeth Dr.   |   |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple stab wounds<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |   |   |   |  |
| 24. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |                  |   |   |   |  |
| 25. DATE OF OPERATION   |                  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED?                        |   |   | 27. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 28. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 29. TIME OF INJURY<br>HOUR 1:45 P.M.<br>MONTH 10<br>DAY 27<br>YEAR 1986 |   | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject stabbed |  |
| 31. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK   |                  | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home      |   | 33. LOCATION<br>STREET 6116 Macbeth Dr., Balto.<br>CITY OR TOWN<br>COUNTY<br>STATE MD           |  |
| 34. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |   |   |  |
| 35. ACTUAL SIGNATURE<br>William M. Zane   |                  | 36. TITLE (SPECIFY)<br>M.D. Assistant                                   |   | 37. MEDICAL EXAMINER<br>DATE SIGNED 10/28/86  |  |
| 38. EXAMINER'S NAME<br>(TYPE OR PRINT)<br>William M. Zane, M.D.   |                  | 39. ADDRESS<br>111 Penn St. Balto. MD.                                  |   |   |  |
| 40. BURIAL, CREMATION, REMOVAL<br>(REPLY)<br>Burial   |                  | 41. DATE<br>11-1-86   |   | 42. NAME OF CEMETERY OR CREMATORY<br>King Mem. Park   |  |
| 43. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE M.D.  |                  | 44. DATE REC'D. BY REGISTRAR<br>OCT 31 1986                             |   |   |  |
| 45. FUNERAL DIRECTOR<br>NAME<br>Reed Funeral Home   |                  | 46. ADDRESS<br>5209 YORK RD   |   | 47. REGISTRAR'S SIGNATURE   |  |

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00-21830

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and official filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|  |  |  |  |   |  |   |  |  |  |  |                            |                              |  |
|--|--|--|--|---|--|---|--|--|--|--|----------------------------|------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 6 2 8 3 9 2                                |                            |                              |  |
| 1- FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |  |  |                            |                              |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARGARET ELLEN LOWERY   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 22 86   |  |  | 2b. HOUR<br>4 <sup>10</sup> P <sup>M</sup>                         |  |                            |                              |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 05 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS   |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |                            |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |  |                            |                              |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE,  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PRESSER                     |  |  | 12b. KIND OF INDUSTRY<br>FACTORY<br>GARMENT MANU-                  |  |                            |                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  | 12b. KIND OF INDUSTRY                        |                            |                              |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>BALTIMORE, MD.<br>634 WILDWOOD PARKWAY, 21229  |  |  |                            |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SIMON BANKS  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ROSA STREET  |  |   |  |  |  |  |                            |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>NO.  |  | 16b. SOCIAL SECURITY NO.<br>212-05-7963  |  | 17. INFORMANT<br>ADDRESS P. O. BOX 6187<br>JOHN W. LOWERY 177 NORWOOD ST. NEWARK, N. J.   |  |   |  |  |  |  |                            |                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) OVARIAN CANCER<br>DUE TO, OR AS A CONSEQUENCE OF (b) WITH MALIGNANT ASCITIS.<br>DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>RENAL FAILURE |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                            |                              |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                            |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |                            |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |                            |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-13-86 to 10-22-86, that (I) (we) last saw the deceased alive on 10-22-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  | 22b. SIGNATURE<br>Sudhir Patel               |                            | 22c. DATE SIGNED<br>10-22-86 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SUDHIR. PATEL   |  |  |  | 22e. ADDRESS<br>LIBERTY MEDICAL CENTRE<br>BALTIMORE   |  |   |  |  |  |  |                            |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>10/28/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  | 23e. DATE REC'D. BY REGISTRAR  |  |  | 23f. REGISTRAR'S SIGNATURE |                              |  |
| 24. NUMBER & SONS FUNERAL HOME, INC.<br>NAME ADDRESS<br>2501 GYNNIS FALLS PKWY. BALTIMORE, MD. 21216   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 23 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>John A. Anderson   |  |  |                            |                              |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove certificate pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | HTLVIII positive  |  | 8 0 2 8 3 9 3   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Mildred A LOY   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 29 86   |  | 2b. HOUR<br>1105A M   |  |   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 15 19   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Indiana  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNKNOWN  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fed GOVT   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD  |  |   |  | 13b. COUNTY<br>ST. MARYS  |  | 13c. CITY OR TOWN<br>GREAT MILLS  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 13e. STREET ADDRESS / ZIP CODE<br>470 GREENVIEW   |  |   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JULIUS  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ADELINE STALLMAN         |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>UNKNOWN  |  |   |  | 16b. SOCIAL SECURITY NO.<br>578-09-5789   |  | 17. INFORMANT<br>Joseph Royston   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                          |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>9/30/86<br>10/16/86   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Abdominal Aortic Aneurysm<br>Prolonged mechanical Ventilation                         |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 23</u> , 19 <u>86</u> , to <u>Oct 29</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Oct 29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Bryan K. Bartle MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>10/29/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRYAN K. BARTLE MD   |  |   |  | 22e. ADDRESS<br>225. GREENE ST. BALTIMORE MD 21201  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov.1, 1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Memorial  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>California St. Mary's       |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. Clarke Mattingley  |  |   |  | ADDRESS<br>Leonardtwn, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1986                               |  | 25b. REGISTRAR'S SIGNATURE<br>Adrian Bonifacio  |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be vacated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                     |  |  |  |         |  |
|--|--|--|--|--|--|---|--|-------------------------------------|--|--|--|---------|--|
| 1. FOR STATE REGISTRAR   |  | 8 6 2 8 3 9 4  |  | REG. NO.   |  |   |  |                                     |  |  |  |         |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 20. DATE OF DEATH  |  | MONTH   |  | DAY                                 |  | YEAR   |  | 2b HOUR |  |
| ISAIAH LUCAS   |  |  |  | SUNDAY, OCT. 19, 1986  |  |   |  |                                     |  |  |  | 1:00P M |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR                     |  | IF UNDER 24 HRS                              |  |         |  |
| MALE   |  | BLACK  |  | APR. 18, 1909  |  | 77  |  | YRS                                 |  | MONTHS                                       |  | DAYS    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN)   |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |         |  |
| SOUTH CAROLINA   |  | US of A  |  |  |  |   |  | BALTIMORE CITY                      |  |  |  | MD.     |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |                                     |  |  |  |         |  |
| BALTIMORE  |  | 2532 W. LAFAYETTE AVENUE   |  | RETIRED  |  | MINISTER  |  |                                     |  |  |  |         |  |
| 13a STATE  |  | 13b COUNTY   |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?   |  | 13e STREET ADDRESS / ZIP CODE       |  |  |  |         |  |
| MARYLAND   |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 2532 W. LAFAYETTE AVE. 21216        |  |  |  |         |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  |  |  |   |  |                                     |  |  |  |         |  |
| ALSTON   |  | CHARLOTTE  |  |  |  |   |  |                                     |  |  |  |         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT   |  | ADDRESS   |  |                                     |  |  |  |         |  |
| NO   |  | 217 01 2185  |  | MRS. RUTH CLAUSELLE  |  | 2532 W. LAFAYETTE AVE.  |  |                                     |  |  |  |         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory failure   |  |  |  |  |  |   |  |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |         |  |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of stomach   |  |  |  |  |  |   |  |                                     |  |  |  |         |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |                                     |  |  |  |         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Renal failure  |  |  |  |  |  |   |  |                                     |  |  |  |         |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                 |  |                                     |  |  |  |         |  |
| December 85,   |  | cancer of stomach  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |                                     |  |  |  |         |  |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                                     |  |  |  |         |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                                     |  |  |  |         |  |
|  |  | P.M. 19  |  |  |  |   |  |                                     |  |  |  |         |  |
| 21d INJURY OCCURRED  |  | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                      |  | 21f LOCATION   |  | CITY OR TOWN  |  | COUNTY                              |  | STATE  |  |         |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |  |   |  |                                     |  |  |  |         |  |
| 22a I certify that (I) (this hospital) attended the deceased from 19 76 to present 19 , that (I) (we) last saw the deceased alive on 10/16 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                     |  |  |  |         |  |
| 22b SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED   |  |                                     |  |  |  |         |  |
| B. P. THADA  |  |  |  |  |  | 10/20/86  |  |                                     |  |  |  |         |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS  |  |  |  |   |  |                                     |  |  |  |         |  |
| B. P. THADA  |  | 5356 Reisterstown Rd   |  |  |  | MD 21215  |  |                                     |  |  |  |         |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION  |  | CITY OR TOWN                        |  | COUNTY                                       |  | STATE   |  |
| BURIAL   |  | 10/25/86   |  | ARBUTUS MEMORIAL PARK  |  | BALTIMORE (BALTO.)  |  |                                     |  |  |  | MD.     |  |
| 24 FUNERAL DIRECTOR  |  | 25a DATE REC'D BY REGISTRAR  |  | 25b REGISTRAR'S SIGNATURE  |  |   |  |                                     |  |  |  |         |  |
| NAME   |  |  |  |  |  |   |  |                                     |  |  |  |         |  |
| LEWIS T. GWYNN   |  | 4517 PARK HEIGHTS AVENUE   |  |  |  |   |  |                                     |  |  |  |         |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28393

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ST. GEORGE LUCAS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/24/86</b>                             |   | 2b. HOUR<br><b>7:30A M</b>   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/24/08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN<br><b>78</b> YRS                       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>SWANSEA CO VA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1822 W Fayette St 21223</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Lucas</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann</b>                        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>26-10-2731A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Rose Lucas 1822 W Fayette St</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pneumonia and sepsis and CHF</b> 14 days<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebral Vascular Accident</b> 30 days |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CHF, COPD, ASCVD</b>  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 9, 1986</b> to <b>October 24, 1986</b> , that (I) (we) last saw the deceased alive on <b>October 24, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>M.W. Barber, M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>10/24/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. W. Barber, M.D.</b>   |  | 22e. ADDRESS<br><b>901 Caton Ave.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CITY)<br><b>Burial</b>   | 23b. DATE<br><b>10/29/86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD Veterans</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CANAWAHSVILLE MD</b>                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>W.P. Hayes 638 N Broom St</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2, and fill in the space for the funeral director's name with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





00-22473

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the Division of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8828390

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |   |  |  |
|---|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM LUCHINSKY</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-20-1986</b>                            |   | 2b. HOUR<br>MIN.<br><b>11:16 PM</b>                             |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 27 1915</b>  |   |  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12c. APT. D<br><b>APT. D</b>  |   |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISAAC LUCHINSKY</b>  |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE<br><b>FEINSTEIN</b>   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-0728</b>   |   | 17. INFORMANT<br>ADDRESS (21209)<br><b>ESTHER LUCHINSKY 2905 MARNAT RD., APT. D</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CHRONIC RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HTN</b> |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one hour</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-10</b> , 19 <b>86</b> , to <b>10-20</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10-20</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not see the body after death, view the body after death.)  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   | 22c. DATE SIGNED<br><b>10/20/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jorge F. Gonzalez, MD</b>   |  | 22e. ADDRESS<br><b>Sinai Hospital</b>  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, OR REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10/20/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI ISRAEL CEMETERY</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |   | 25. DATE REC'D BY REGISTRAR<br><b>OCT 29 1986</b>   |   |  |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |  |  |

MEDICAL CERTIFICATION

29

00-55453

212-1011 10106

MINIATURE



00-22110

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28391

|  |  |   |   |   |  |   |                            |   |  |
|--|--|---|---|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CHARLENE N. LYONS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 18, 1986   |   |  | 2b. HOUR<br>9:25 A  |                            |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 27, 1946   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS.  |                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Florida   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                            |                            |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary General |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Electric Co  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |   | 13b. COUNTY<br>Howard   |  | 13c. CITY OR TOWN<br>Glenelg  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nelson Jolissant   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Nelson  |  |   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>465 80 1025  |   | 17. INFORMANT<br>ADDRESS<br>James Patrick Lyons 14210 Day Farm Road 21737   |  |   |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Megakaryocytic Leukemia (M7)</u>   |  |   |   |   |  |   |                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 hours<br>4 days<br>2 years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>   |  |   |   |   |  |   |                            |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                            |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |                            |   |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>10/14/86</u> , to <u>10/18/86</u> , that <del>it</del> (we) last saw the deceased alive on <u>10/18/86</u> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above; <del>(I)</del> (we) <del>(did)</del> (did not) view the body after death. |  |   |   |   |  |   |                            |   |  |
| 22b. SIGNATURE<br><u>Shanti Ramesh</u>   |  |   | DEGREE <u>Resident Physician</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   |                            | 22c. DATE SIGNED<br>10/18/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SHANTI RAMESH   |  |   | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL<br>BALTIMORE, MD 600 N. WOLFE ST. 21205  |   |  |   |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Oct 22'86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn   |  | 23d. LOCATION<br>CITY OR TOWN<br>Howard   |                            | 23e. STATE<br>Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry H. Witzke & Family Funeral Home<br>Inc. 4112 Old Columbia Pike Ellicott City   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1986                                   |   | 25b. REGISTRAR'S SIGNATURE |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon papers, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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-20141

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REC. NO. 2 8 3 9 8

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN CONCANNON LYSTON  |  | OCTOBER 4, 1986  |  | M  |  |
| 3. SEX<br>Male   | 4 RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 25, 1900   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86<br>YRS.                                 |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b CITIZEN OF WHAT COUNTRY?<br>USA   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3240 Abell Ave. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant                  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Balto. City        |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland   | 13b COUNTY   | 13c CITY OR TOWN<br>Baltimore  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br>3240 Abell Ave. 21218 |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Michael Lyston   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine J. Concannon   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>211-22-7262  |  | 17 INFORMANT<br>ADDRESS<br>Catherine M. Lyston Same                          |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |
| MEDICAL CERTIFICATION  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 78 to 10 / 4 19 86 that (I) (we) last saw the deceased alive on 9 / 12 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.   |  |  |  |  |  |
| 22b SIGNATURE<br>Gregory J. Walker MD  |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |  | 22c DATE SIGNED  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gregory Walker, M.D.   |  | 22e ADDRESS<br>3300 N. Calvert St. Baltimore, Md. 21218  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b DATE<br>Oct. 7, 1986   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley                          |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium, Baltimore Co., Md.  |  | 23e DATE REC'D. BY REGISTRAR   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  | ADDRESS<br>6500 York Rd.   |  | 25a DATE REC'D. BY REGISTRAR<br>OCT 06 1986                                  |  |
| 25b REGISTRAR'S SIGNATURE<br>John E. Davidson  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1342 + 1343 = 2685  
1344 + 1345 = 2689  
1346 + 1347 = 2693  
1348 + 1349 = 2697  
1350 + 1351 = 2701  
1352 + 1353 = 2705  
1354 + 1355 = 2709  
1356 + 1357 = 2713  
1358 + 1359 = 2717  
1360 + 1361 = 2721  
1362 + 1363 = 2725  
1364 + 1365 = 2729  
1366 + 1367 = 2733  
1368 + 1369 = 2737  
1370 + 1371 = 2741  
1372 + 1373 = 2745  
1374 + 1375 = 2749  
1376 + 1377 = 2753  
1378 + 1379 = 2757  
1380 + 1381 = 2761  
1382 + 1383 = 2765  
1384 + 1385 = 2769  
1386 + 1387 = 2773  
1388 + 1389 = 2777  
1390 + 1391 = 2781  
1392 + 1393 = 2785  
1394 + 1395 = 2789  
1396 + 1397 = 2793  
1398 + 1399 = 2797  
1400 + 1401 = 2801  
1402 + 1403 = 2805  
1404 + 1405 = 2809  
1406 + 1407 = 2813  
1408 + 1409 = 2817  
1410 + 1411 = 2821  
1412 + 1413 = 2825  
1414 + 1415 = 2829  
1416 + 1417 = 2833  
1418 + 1419 = 2837  
1420 + 1421 = 2841  
1422 + 1423 = 2845  
1424 + 1425 = 2849  
1426 + 1427 = 2853  
1428 + 1429 = 2857  
1430 + 1431 = 2861  
1432 + 1433 = 2865  
1434 + 1435 = 2869  
1436 + 1437 = 2873  
1438 + 1439 = 2877  
1440 + 1441 = 2881  
1442 + 1443 = 2885  
1444 + 1445 = 2889  
1446 + 1447 = 2893  
1448 + 1449 = 2897  
1450 + 1451 = 2901  
1452 + 1453 = 2905  
1454 + 1455 = 2909  
1456 + 1457 = 2913  
1458 + 1459 = 2917  
1460 + 1461 = 2921  
1462 + 1463 = 2925  
1464 + 1465 = 2929  
1466 + 1467 = 2933  
1468 + 1469 = 2937  
1470 + 1471 = 2941  
1472 + 1473 = 2945  
1474 + 1475 = 2949  
1476 + 1477 = 2953  
1478 + 1479 = 2957  
1480 + 1481 = 2961  
1482 + 1483 = 2965  
1484 + 1485 = 2969  
1486 + 1487 = 2973  
1488 + 1489 = 2977  
1490 + 1491 = 2981  
1492 + 1493 = 2985  
1494 + 1495 = 2989  
1496 + 1497 = 2993  
1498 + 1499 = 2997  
1500 + 1501 = 3001  
1502 + 1503 = 3005  
1504 + 1505 = 3009  
1506 + 1507 = 3013  
1508 + 1509 = 3017  
1510 + 1511 = 3021  
1512 + 1513 = 3025  
1514 + 1515 = 3029  
1516 + 1517 = 3033  
1518 + 1519 = 3037  
1520 + 1521 = 3041  
1522 + 1523 = 3045  
1524 + 1525 = 3049  
1526 + 1527 = 3053  
1528 + 1529 = 305

00-22238

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.

2 8 3 9 9

|   |  |  |   |  |   |  |  |   |  |
|---|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>W. H. Thompson</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/23/86</b>  |  |   | 2b. HOUR<br><b>240 PM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 - 12 - 10</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Chester S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Calverton County MD</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Calverton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Inglesbrook Nursing Home</b> |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Singer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>MD</b>   |  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br><b>703 Allendale 21229</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hazel Thompson</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elaine Lettice</b>  |  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Army</b>  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>579-65-8071</b>  |  |  | 17. INFORMANT<br>NAME ADDRESS<br><b>Isarel William 703 Allendale St (29)v</b><br><b>M/R - Inglesbrook 323 Harbor Lane</b> |  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sick Sinus Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Altersilvatic Cardiovascular disease</b>                          |  |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Burr Hole Skull, Organic Brain Syndrome</b>   |  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |   |  |
| 21d. INJURY OCCURRED:<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9.16.86</b> to <b>10.23.86</b> that (I) (we) last<br>saw the deceased alive on <b>10.13.86</b> and that in (my) (our) opinion death occurred on the date and hour (and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  | DEGREE  |  |   | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/24/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DARSHAN S. S. ALOTA</b>   |  |  | 22e. ADDRESS<br><b>1600 Mt Royal Ave, Balt 21217</b>  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/27/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Garrison Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice FSPA</b>   |  |  |   |  | ADDRESS<br><b>1300 Eutaw Place</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1986</b>          |   |  |
|   |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |   |  |

00-13383

8-11-11

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RECEIVED

100-13383



00-20160

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

86 28400

|  |         |  |  |   |  |   |  |   |  |                          |  |         |  |      |  |          |  |
|--|---------|--|--|---|--|---|--|---|--|--------------------------|--|---------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | MONTH                    |  | DAY     |  | YEAR |  | 2b. HOUR |  |
| ROBERT   |         |  |  |   |  | MAC ENERY   |  | 10  |  | 6                        |  | 19      |  | 86   |  | 8:55 A M |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD |  | MONTH   |  | DAY  |  | YEAR     |  |
| Male   | Cauc.   | 11/2/17  |  | 68  |  | YRS.  |  |   |  | 10                       |  | 6       |  | 19   |  | 86       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                          |  |         |  |      |  |          |  |
| New York   |         | USA  |  | WIDOWED   |  | DIVORCED  |  | Baltimore City  |  |                          |  |         |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |         |  |      |  |          |  |
| Baltimore  |         | 3117 Kenyon Ave.   |  | General Cont.   |  | self-employ   |  |   |  |                          |  |         |  |      |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                          |  |         |  |      |  |          |  |
| Maryland   |         | --   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3117 Kenyon Ave, 21213  |  |                          |  |         |  |      |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| William Mac Enery  |         | Anna Duklauer  |  |   |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                          |  |         |  |      |  |          |  |
| NO   |         | 081-05-8061  |  | Edward MacEnery, Brother,   |  | 33063   |  |   |  |                          |  |         |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART 1 DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | Arteriosclerotic cardiovascular disease                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                          |  |         |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         | DUE TO, OR AS A CONSEQUENCE OF   |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | (c)   |  |                          |  |         |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | (head only)   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |         |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY  |  | STATE                    |  |         |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)   |  | M.D. Assistant  |  | MEDICAL EXAMINER  |  | DATE SIGNED              |  | 10-6-86 |  |      |  |          |  |
| ACTUAL SIGNATURE   |         | Charles P. Kokes, M.D.   |  | ADDRESS   |  | 111 Penn St., Balto., MD  |  | 21201   |  |                          |  |         |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | CITY OR TOWN  |  | COUNTY                   |  | STATE   |  |      |  |          |  |
| BURIAL   |         | 10/10/86   |  | Mt. Hope Cemetery   |  | Ardsley, N.Y.   |  |   |  |                          |  |         |  |      |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |         | 3331 Brehms Lane   |  | 25a. DATE REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                          |  |         |  |      |  |          |  |
| SCHIMUNEK FUNERAL HOME, Balto., Md. 21213  |         |  |  | OCT 07 1986   |  |   |  |   |  |                          |  |         |  |      |  |          |  |

88400

00103-00



NON MED PER MR. GREGORY BY DR. KO  
RECEIVED DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver the certificate to the funeral home for filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |                                |  | 86 28401            |  |              |  |
|---|--|--|--|---|--|---|--|--------------------------------|--|---------------------|--|--------------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |   |  |                                |  |                     |  |              |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH              |  | MONTH DAY YEAR      |  | 2b. HOUR P M |  |
| ADAM  |  | J.   |  |   |  | J. MACK   |  | OCTOBER 31, 1986               |  |                     |  | 1:57 P M     |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR             |  | 8. IF UNDER 24 HRS. |  |              |  |
| Male  |  | White  |  | August 3 1916   |  | 70 YRS.   |  | MONTHS DAYS                    |  | HOURS MIN.          |  |              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                |  |                     |  |              |  |
| Maryland  |  | U.S.A.   |  |   |  | BALTIMORE CITY  |  |                                |  |                     |  | MD.          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                |  |                     |  |              |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  | Painter   |  | Eastern Prod.   |  |                                |  |                     |  |              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE   |  | 13c. COUNTY   |  | 13d. CITY OR TOWN   |  | 13e. STREET ADDRESS / ZIP CODE |  |                     |  |              |  |
| Maryland  |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 509 S. Bradford St. 21224      |  |                     |  |              |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                |  |                     |  |              |  |
| Maciej  |  | Anna   |  |   |  |   |  |                                |  |                     |  |              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                |  |                     |  |              |  |
| no  |  | 213-28-6659  |  | Helen Mach  |  | 509 S. Bradford St. 21224   |  |                                |  |                     |  |              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Approximate interval between onset and death: <u>5 min</u>  |  |  |  |   |  |   |  |                                |  |                     |  |              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |   |  |   |  |                                |  |                     |  |              |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                |  |                     |  |              |  |
|   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                |  |                     |  |              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |                                |  |                     |  |              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                |  |                     |  |              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> , 19 <u>86</u> , to <u>10/31</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/31</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                                |  |                     |  |              |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |                                |  |                     |  |              |  |
| NONE  |  |  |  |   |  | 10/31   |  |                                |  |                     |  |              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |                                |  |                     |  |              |  |
| AMY KLION   |  | 600 N. WOLFEST. BALTO., MD 21205   |  | JOHNS HOPKINS HOSPITAL  |  |   |  |                                |  |                     |  |              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                |  |                     |  |              |  |
| Burial  |  | Nov 4 1986   |  | St. Stanislaus  |  | Baltimore Md.   |  |                                |  |                     |  |              |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |                     |  |              |  |
| Lilly & Zeiler, Inc.  |  | 21231 Eastern Ave.   |  | NOV 5 1986  |  | Julia Gordon-Randall  |  |                                |  |                     |  |              |  |

(15-10)



00-20166

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28402  
REG. NO.

|   |        |  |                  |   |                  |   |           |
|---|--------|--|------------------|---|------------------|---|-----------|
| 1- FOR STATE REGISTRAR  |        | 2a. DATE KNOWN OF DEATH  |                  | MONTH DAY YEAR  |                  | 2b. HOUR  |           |
| 1 DECEASED NAME (TYPE OR PRINT)   |        | FIRST MIDDLE LAST  |                  | Walter Mackey   |                  | 10-2 1986   |           |
| 3 SEX   | 4 RACE | 5 DATE OF BIRTH  | 6 AGE (IN YEARS) | IF UNDER 1 YR   | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD  | 7d. HOUR  |
| MALE  | BLACK  | 12-23-26   | 59 YRS.          | MONTHS DAYS   | HOURS MIN        | 10-2 1986   | 9:40 P.M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |           |
| T MARYLAND  |        | U.S.A.   |                  |   |                  | Baltimore City, MD  |           |
| 10 CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                            |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |           |
| Baltimore   |        | Lutheran Hospital  |                  | JANITORIAL  |                  | -   |           |
| 13a. STATE  |        | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |                  | 13d. STREET ADDRESS   |           |
| MD  |        |  |                  | MD  |                  | 21207 2121 WINDSOR GARDEN LANE                                      |           |
| 14. FATHER'S NAME   |        | 15. MOTHER'S MAIDEN NAME   |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |                  | 16b. SOCIAL SECURITY NO.  |           |
| FIRST MIDDLE LAST   |        | FIRST MIDDLE LAST  |                  | YES   |                  | 16-921-219 212-20-3382  |           |
| 17. INFORMANT   |        | ADDRESS  |                  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |           |
| EDITH MACKEY  |        | 7305 LINDEN AVE.   |                  | PART I DEATH WAS CAUSED BY:   |                  |   |           |
|   |        |  |                  | IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease   |                  |   |           |
|   |        |  |                  | DUE TO, OR AS A CONSEQUENCE OF  |                  |   |           |
|   |        |  |                  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |                  |   |           |
|   |        |  |                  | DUE TO, OR AS A CONSEQUENCE OF  |                  |   |           |
|   |        |  |                  | (c)   |                  |   |           |
|   |        |  |                  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                  |   |           |
| 19a. DATE OF OPERATION  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                  | 20 AUTOPSY?   |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |           |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                  |   |           |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                  |   |           |
| 22a. I certify that I took charge of the remains described above, held on   |        | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                  | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |           |
| ACTUAL SIGNATURE  |        | TITLE (SPECIFY)  |                  | DATE SIGNED   |                  |   |           |
| Margarita A. Korell, M.D.   |        | Assistant  |                  | 10-3-86   |                  |   |           |
| EXAMINER'S NAME (TYPE OR PRINT)   |        | ADDRESS  |                  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                  | 23b. DATE   |           |
| Margarita A. Korell, M.D.   |        | 111 Penn St., Balto., Md. 21201  |                  | BURIAL  |                  | 10-8-86   |           |
| 24 FUNERAL DIRECTOR   |        | 25a. DATE REC'D BY REGISTRAR   |                  | 25b. REGISTRAR'S SIGNATURE  |                  | 23c. NAME OF CEMETERY OR CREMATORY                                  |           |
| MARCH FUNERAL HOMES   |        | OCT 07 1986  |                  |   |                  | GARRISON FOREST   |           |
| 1101 E. NORTH AVE.  |        |  |                  |   |                  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |           |
|   |        |  |                  |   |                  | OWINGS MILLS MD   |           |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY CHANGES ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



0-20713

Item #16b, Film G 621, 11.19.86 ra  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28403

|   |  |  |  |  |  |   |  |  |  |                               |  |   |  |                            |  |  |  |
|---|--|--|--|--|--|---|--|--|--|-------------------------------|--|---|--|----------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED   |  | MONTH                         |  | DAY   |  | YEAR                       |  | 2b. HOUR                                     |  |
| Vincent   |  | E.   |  | Mahoney  |  |   |  | XX   |  | 10-7                          |  | 1986  |  |                            |  | M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY  |  | IF UNDER 1 YR.<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN |  | 7c. DATE PRONOUNCED DEAD  |  | MONTH DAY YEAR             |  | 2d. HOUR                                     |  |
| Male  |  | Caucasian  |  | May 23, 1958   |  | 28 YRS.   |  |  |  |                               |  | 10-7  |  | 1986                       |  | 9:20 P.M.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |                               |  |   |  |                            |  |  |  |
| Conn  |  | U.S.A.   |  |  |  | Baltimore City,   |  |  |  |                               |  |   |  |                            |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS   |  |  |  |                               |  |   |  |                            |  |  |  |
| Baltimore   |  | University Hospital - STU  |  | Food Service   |  | Domino Pizza  |  |  |  |                               |  |   |  |                            |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSURE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |                               |  |   |  |                            |  |  |  |
| Maryland  |  | P. G.  |  | Upper Marlboro   |  |   |  | 17128 Fairway View Lane 20772  |  |                               |  |   |  |                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |  |   |  |  |  |                               |  |   |  |                            |  |  |  |
| James William Mahoney   |  | A. Ruth Woike  |  |  |  |   |  |  |  |                               |  |   |  |                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |                               |  |   |  |                            |  |  |  |
| No  |  | N/A  |  | 048-54-6580  |  | Ruth Mahoney Same as 13 A-E   |  |  |  |                               |  |   |  |                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Blunt Trauma to Head<br>8121<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |   |  |  |  |                               |  |   |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |                               |  |   |  |                            |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  |                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                            |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1:29 P.M. 10-7 1986  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>passenger in auto/truck impact                |  |                               |  |   |  |                            |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Collington Rd., between Rt. 301 & Rt. 50, Bowie, Prince George's Co., Md. |  |                               |  |   |  |                            |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion, death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |  |                               |  |   |  |                            |  |  |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth   |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  |  |  |                               |  | DATE SIGNED<br>10-8-86  |  |                            |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |  |  | ADDRESS  |  |   |  |  |  |                               |  |   |  |                            |  |  |  |
| Dennis F. Smyth, M.D.   |  |  |  | 111 Penn St., Balto., Md. 21201  |  |   |  |  |  |                               |  |   |  |                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY  |  |  |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                            |  |  |  |
| Cremation   |  |  |  | 10/09/86   |  |   |  | Lee Cremetory  |  |                               |  | Clinton Prince George's Md.   |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lee Funeral Home, Inc.<br>6633 Old ALEXander Ferry Rd. Clinton, Md 20735  |  |  |  |  |  |   |  |  |  |                               |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
 DHMH - 17  
 (VR A15 ME)

OCT 10 1986

202 edition 1978

1/1/78





00-20324

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 28404

|   |  |  |   |   |  |  |   |   |  |  |
|---|--|--|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Kathryn L. Malinauskas</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 6 86</b>                       |   |  | 2b. HOUR<br><b>1714</b> M  |   |   |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 19 15</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                      |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, Md.</b> MD.                 |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Line Worker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Calvert Dist.</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Arbutus</b>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>5210 Arbutus Ave. 21227</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Hedrick</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Burnhardt</b> |   |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>207-05-3358</b>                              |   | 17. INFORMANT<br><b>Peter J. Malinauskas</b>                       |  |   |   | ADDRESS<br><b>322 Osborne Ave. 21228</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe generalized atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>Previous multiple myocardial infarctions; Chronic renal failure; Diabetes</b>  |  |  |   |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)        |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 82</b> to <b>Oct 6 86</b> that (I) (we) lost<br>saw the deceased alive on <b>Oct 4 86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |   |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>10-6-86</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>N. Machiran, M.D.</b>   |  |  |   |   | 22e. ADDRESS<br><b>720 Maiden Choice La. Balto #21228</b>          |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>10/10/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Maryland</b>                   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 08 1986</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the folder and return it to the funeral director. The funeral director should file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified of this.

00-2082

TO 6 66 1711

Latvian I. Melnikova

WHITE 7 12 12 VI

Baltimore City, Md.

Baltimore St. Anne's Hospital Homekeeper

Mr. Arthur 2210 Arthur Ave. X

207-053-350 Joe Melnikova



N. MacLennan, N.D. 750 Nelson Choice Is. N.Y. 421228

00-22444

FOR 21e, 21f, 22a, G-622, DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 1- STATE REGISTRAR M.E./12/5/86 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 28-05

|  |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
|--|--|---------|--|---|--|-------------------|--|--|--|------------------|--|---|--|---|--|--|--|------|--|---------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST              |  | 2a. DATE KNOWN OF DEATH  |  | MONTH            |  | DAY   |  | YEAR  |  | 2b. HOUR                                     |  |      |  |                     |  |  |  |
| JOHN   |  | R.      |  | Mallalieu   |  |                   |  | 10   |  | 24               |  | 19  |  | 86  |  | M  |  |      |  |                     |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  | MONTH   |  | DAY  |  | YEAR |  | 2d. HOUR            |  |  |  |
| Male   |  | White   |  | 9-12-1950   |  | 36                |  | YRS.   |  |                  |  | 10  |  | 24  |  | 19   |  | 86   |  | 11:45               |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |  |  |      |  |                     |  |  |  |
| Maryland   |  |         |  | U.S.A.  |  |                   |  |  |  |                  |  | Baltimore City  |  |   |  |  |  |      |  |                     |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                   |  |  |  |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |      |  |                     |  |  |  |
| Baltimore  |  |         |  | Union Memorial Hosp.  |  |                   |  |  |  |                  |  | Welder  |  |   |  |  |  |      |  |                     |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  | 13a. STATE  |  |                   |  | 13b. COUNTY  |  |                  |  | 13c. CITY OR TOWN   |  |   |  | 13d. INSIDE CITY LIMITS?                     |  |      |  | 13e. STREET ADDRESS |  |  |  |
| Maryland   |  |         |  | -----   |  |                   |  | Baltimore  |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  | 2923 North Charles St. 21218                 |  |      |  |                     |  |  |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME                                    |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| C. Robert Mallalieu  |  |         |  | Dorothy M. Harpster   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  | 16b. SOCIAL SECURITY NO.                                    |  |                   |  | 17. INFORMANT  |  |                  |  | ADDRESS   |  |   |  |  |  |      |  |                     |  |  |  |
| No   |  |         |  | 212-56-9515   |  |                   |  | C.R.Mallalieu  |  |                  |  | 2923 N. Charles St. 21218   |  |   |  |  |  |      |  |                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |      |  |                     |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| IMMEDIATE CAUSE (a) <u>Alprazolam Intoxication</u>   |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| (b) _____  |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| (c) _____  |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                   |  |  |  |                  |  |   |  | 20. AUTOPSY?  |  |  |  |      |  |                     |  |  |  |
|  |  |         |  |   |  |                   |  |  |  |                  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |      |  |                     |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR PRIMARY CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY   |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
|  |  |         |  | ? P.M. 10 24 1986   |  |                   |  | Subject used drug  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                   |  | 21f. LOCATION  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
|  |  |         |  | home  |  |                   |  | 2507 N. Charles Street, Baltimore, Md.   |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| 22a. I certify that I took charge of the person described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |         |  |   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |                   |  |  |  |                  |  |   |  | DATE SIGNED   |  |  |  |      |  |                     |  |  |  |
| Dennis F. Smyth, M.D.  |  |         |  | M.D. Assistant  |  |                   |  |  |  |                  |  |   |  | 10-25-86  |  |  |  |      |  |                     |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |                   |  |  |  |                  |  |   |  |   |  |  |  |      |  |                     |  |  |  |
| Dennis F. Smyth, M.D.  |  |         |  | 111 Penn St., Balto., MD                                    |  |                   |  |  |  |                  |  |   |  | 21201   |  |  |  |      |  |                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                  |  | 23d. LOCATION   |  |   |  | COUNTY                                       |  |      |  | STATE               |  |  |  |
| Cremation  |  |         |  | 10-27-86  |  |                   |  | Greenmount   |  |                  |  | Baltimore City  |  |   |  | Maryland                                     |  |      |  |                     |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  | 25a. DATE REC'D. BY REGISTRAR                               |  |                   |  |  |  |                  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |      |  |                     |  |  |  |
| Mitchell-Wiedefeld Home  |  |         |  | 6500 York Road 21212  |  |                   |  |  |  |                  |  |   |  | OCT 28 1986   |  |  |  |      |  |                     |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MDHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00-2244

UNITED STATES

DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

INVESTIGATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refer to the instructions. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28-00

REG. NO.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>Palage D. Mallon   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-23-86  |  | 2b. HOUR<br>4:40 AM  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUC.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 18 1960  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                |  |
| 7a. BIRTHPLACE<br>(STATE OF FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>416 S. BENSAL ST. 21224                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALEXANDER   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LECKATIA  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>220-14-4770  |  | 17. INFORMANT<br>ADDRESS<br>Wm. J. Mallon, Jr. - 357 WHITFIELD RD. 21228 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial Ischemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes mellitus</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>hours</u><br><u>years</u> |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10/25</u> to <u>current</u> , 19 <u>86</u> , that (1) (we) lost<br>saw the deceased alive on <u>10/22/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>John R. Burton</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/23/86  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John R. BURTON   |  | 22e. ADDRESS<br>4540 EASTERN AVE BALTO MD 21224  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>10/25/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CARL LAWN   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER LABROWSKI  |  | ADDRESS<br>1005 DUNDALK AVE  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Burton</u>   |  |  |  |

MEDICAL CERTIFICATION

82-55-01

*[Faint, illegible handwritten text covering the majority of the page]*

Oct 18 1955

00-22653

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to obtain a post-mortem examination within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 86 28407   |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SELMA MANDEL</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 28, 1986</b> |   |  | 2b. HOUR<br><b>3:43 A.M.</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JANUARY 13, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3601 FORDS LANE, APT. 822 (21215)</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3601 FORDS LANE, APT. 822(21215)</b>  |  |
| 14. FATHER'S NAME<br><b>SAUL</b> MIDDLE  |  |   |  | 15. MOTHER'S MAIDEN NAME<br><b>ESTHER</b> MIDDLE   |  | 16. SCHLOSSBERG   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>MRS. ESTHER WAXMAN 2503 APACHE CIRCLE (21209)</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ATHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIABETES MELLITUS</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minute</b><br><b>year</b><br><b>years</b> |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/28</b> 19 <b>85</b> , to <b>10/28</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10/28</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Craig Haber</b>   |  |   |  | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>10/28/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Craig Haber, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>131 Slade Ave</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10/29/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 30 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

DOWN

2000 C. B. L. M. C. H. D.

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*



00-21239

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 2 8 4 0 8  
REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <del>MANDLEY</del> Carolyn May MANDLEY  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 9 86                         |   |  | 2b. HOUR<br>10 40 A.M.  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 26 29   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>BALTO. MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Choice City Corp  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY Balto 13c. CITY OR TOWN Balto 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 2216 Carbin Rd 21214       |  |  |  |   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Franklin Mohr   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Stapler  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>unknown   |  |  |  | 16b. SOCIAL SECURITY NO.<br>214 24 8644   |  | 17. INFORMANT ADDRESS<br>FAMILY RECORDS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) respiratory insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) metastatic renal cell carcinoma                   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 hrs<br>6 mos   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 6, 19 86, to Oct 9, 19 86, that (I) (we) last saw the deceased alive on Oct 9, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Nadine Semer MD   |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/9/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Nadine Semer   |  |  |  |   | 22e. ADDRESS<br>UMH 225 Greene St Balto MD 21201                               |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |  | 23b. DATE<br>10-13-1986  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH                         |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CO. MD |  |  |
| 24. FUNERAL DIRECTOR<br>EVANS CHAPEL OF CHIMES, TIMONIA   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT. 17 1986                                  |   | 25b. REGISTRAR'S SIGNATURE                                     |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and capably filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified and advised.

BP



0-22752

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28-09  
REG. NO.

|  |  |  |  |   |                                     |  |
|--|--|--|--|---|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDDIE B MANEY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/25/86</b> |   | 2b. HOUR<br>MIN.<br><b>655 A.M.</b> |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07/24/04</b>   |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>1-AYESVILLE N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE MD.</b>   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FSK HOSP</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Woodworker</b>   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lumber</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>PENNSYLVANIA</b>  |  | 13b. CITY OR TOWN<br><b>Lewistown</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | 13d. STREET ADDRESS / ZIP CODE<br><b>Coleman Hotel 17044</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MINNER MANEY</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DELIATHA</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |                                     |  |
| 16b. SOCIAL SECURITY NO.<br><b>237-18-6419</b>   |  | 17. INFORMANT ADDRESS<br><b>Elmer Maney 270 S. Highland Ave.</b>   |  |   |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DEHYDRATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROSTATIC CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |  |   |                                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/11/86</b> to <b>10/25/86</b> , that (I) (we) lost saw the deceased alive on <b>10/24</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                     |  |
| 22b. SIGNATURE<br><b>Jan Czur</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                     | 22c. DATE SIGNED<br><b>10/25/86</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAN CZUR</b>   |  | 22e. ADDRESS<br><b>M.D. FSK HOSPITAL</b>   |  |   |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/27/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cem.</b>  |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>B. Dabrowski &amp; Son</b>  |  | ADDRESS<br><b>2818 E. Baltimore St.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1986</b>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Tindem-Budwig</b>   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be revised by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, any injury, or other traumatic event, the medical examiner must be notified at once.



0-21237

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Their plates remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |   |  |
|---|--|--|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 8 8 2 8 4 1 0<br>REG. NO.   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Ella M. Mann</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 13, 1986</b>             |  |  | 2b. HOUR<br><b>10:14A<sub>M</sub></b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 18, 1904</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital (DOA)</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Wrapper</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3449 Hickory Avenue 21211</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Gideon Milstream</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Josephine Prichard</b> |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217 20 7250</b>   |  | 17. INFORMANT ADDRESS<br><b>Ella M. Dorman 1105 W. 37th Street 21211</b>  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HTASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost                        |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>5-10 yr</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 17</b> , 19 <b>86</b> , to <b>Sept 13</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>Sept 17</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE <b>Dr. Sapir</b>   |  |  |  | DEGREE <b>MD</b>  |   |  |  | 22c. DATE SIGNED<br><b>10/15/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Sapir</b>   |  |  |  | 22e. ADDRESS<br><b>9 E. Chase Street, Baltimore, MD</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>10/17/1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Maryland</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Burgee-Henss Funeral Home, Baltimore, Md. 21211</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. H. Dorman</b>  |  |   |  |

BP



*[Faint, illegible text and markings are visible across the page, possibly bleed-through from the reverse side.]*

00-22658

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                  |  |  |  |
|--|--|--|--|--|--|---|--|----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8023411   |  |  |  |   |  |                                  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR                                     |  |
| VIOLET   |  | A.   |  | MANN   |  |   |  | f 10/29/86                       |  | 4 05 PM                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR               |  | 8. IF UNDER 24 HRS                           |  |
| Female   |  | White  |  | MONTH DAY YEAR<br>08 01 14   |  | 72 YRS  |  | MONTHS DAYS                      |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                  |  |  |  |
| District of Columbia   |  | USA  |  |  |  | BALTIMORE CITY MD.  |  |                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                  |  |  |  |
| BALTIMORE  |  | UNION MEMORIAL HOSPITAL 21218  |  | Housewife  |  |   |  |                                  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE   |  |  |  |
| Maryland   |  | --   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3838 Roland Avenue 21211         |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                                  |  |  |  |
| FIRST MIDDLE LAST<br>Arthur J. Gibson  |  | FIRST MIDDLE LAST<br>XX Nellie J. Fitch  |  |  |  |   |  |                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                                  |  |  |  |
| No   |  | 215-14-9990  |  | Esther Morrison  |  | 9312 Taney Road Manassas, Virginia 22110                            |  |                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |                                  |  |  |  |
| IMMEDIATE CAUSE (a) SEPSIS   |  |  |  |  |  |   |  |                                  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) GANGRENE OF BOWELS + STOMACH  |  |  |  |  |  |   |  |                                  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                  |  |  |  |
| (c) INCARCERATED/STRANGULATED HERNIA   |  |  |  |  |  |   |  |                                  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: DIABETES MELLITUS   |  |  |  |  |  |   |  |                                  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                  |  |  |  |
| 10/29/86   |  | STRANGULATED HERNIA/ABD. SEPSIS  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |                                  |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |                                  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |                                  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/29/86, 19 86, to 10/29/86, 19 86, that (I) (we) last saw the deceased alive on 10/29/86, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |                                  |  |  |  |
| David V. Nasrallah   |  |  |  | 10/29/86   |  |   |  |                                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                                  |  |  |  |
| DAVID V. NASRALLAH   |  | 901 E. UNION PKWY. UNION MEMORIAL HOSPITAL BALTIMORE, MD 21218   |  |  |  |   |  |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. STATE                       |  |  |  |
| Burial   |  | 11/1/86  |  | Meadowridge Mem. Pk.   |  | Baltimore,  |  | Maryland                         |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                  |  |  |  |
| NAME ADDRESS<br>A. Alan Seitz, Jr. 3818 Roland Ave. 21211  |  | OCT 30 1986  |  |  |  |   |  |                                  |  |  |  |

BP

20% COTTON FIBER

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |   |  |  |  |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Margaret Mapp   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 30, 1986   |   | 2b. HOUR<br>M  |  |  |
| 3 SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 29 22  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1427 Kenhill Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1427 Kenhill Avenue 21213  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charley Glassgow   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Washington  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-22-4038   |  | 17. INFORMANT ADDRESS<br>Joseph Worthan 2715 Oakley Avenue  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chest wall hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chest wall recurrence - BREAST CA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>PRIMARY BREAST Cancer</u>  |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>7/86</u><br><u>5/84</u>                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>85</u> , to <u>Oct 30</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Oct 23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Kathy J. Helzlsouer MD</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>10/31/86</u>                              |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>KATHY J. HELZLSOUE</u> MD  |  |  |  |   |  | 22e. ADDRESS<br><u>JOHNS HOPKINS ONCOLOGY CENTER</u><br><u>600 N WOLFE ST. BALTIMORE MD 21205</u>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>11/3/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hills Cemetery                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Md.                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Homes 1101 East North Avenue   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 1986  |   | 25b. REGISTRAR'S SIGNATURE                                       |  |  |

MEDICAL CERTIFICATION



0-21039

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to make an autopsy.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 4 1 3  
REG. NO.

|  |  |  |  |   |   |  |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Amelia M. Marcino   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 12, 1986                   |   | 2b. HOUR<br>M   |  |   |  |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 8, 1901   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4118 Parkside Drive |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Clothing  |   |  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>4118 Parkside Drive 21206 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stephen Rappazzo   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carmela Fazio         |   |   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>no   |  |  | 16b. SOCIAL SECURITY NO<br>214-18-6387                                 |   | 17. INFORMANT<br>Mike J. Marciano   |  |   | 800 Greentree Road<br>Newark, N.J. 07103   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) DIABETES MELLITUS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |   |  |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 10-6, 19 81, to 3-26, 19 85, that (I) (we) last saw the deceased alive on 3-26, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br>Dr. Frank S. Palmisano, Jr.  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>10-13-85   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Frank S. Palmisano, Jr.   |  |  |  |   |   | 22e. ADDRESS<br>5122 Harford Road, Baltimore, Md.  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Oct. 15, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Md.   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986   |   | 25b. REGISTRAR'S SIGNATURE   |   |  |  |

MEDICAL CERTIFICATION

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1. *See* also, e.g., *United States v. Smith*, 199 F.3d 1033, 1037 (9th Cir. 2000).

## NOTES

[illegible]

1957

[illegible]

1950 JAN 18 1950

2-52

3-E-21

DHMH - 16 60M 7/B4  
(VRA 15, 4)

10-50310

RECEIVED JUL 24 1941



NO. 20000  
S-AC-114  
JUL 24 1941  
RECEIVED

100% COTTON FIBER

00-22425

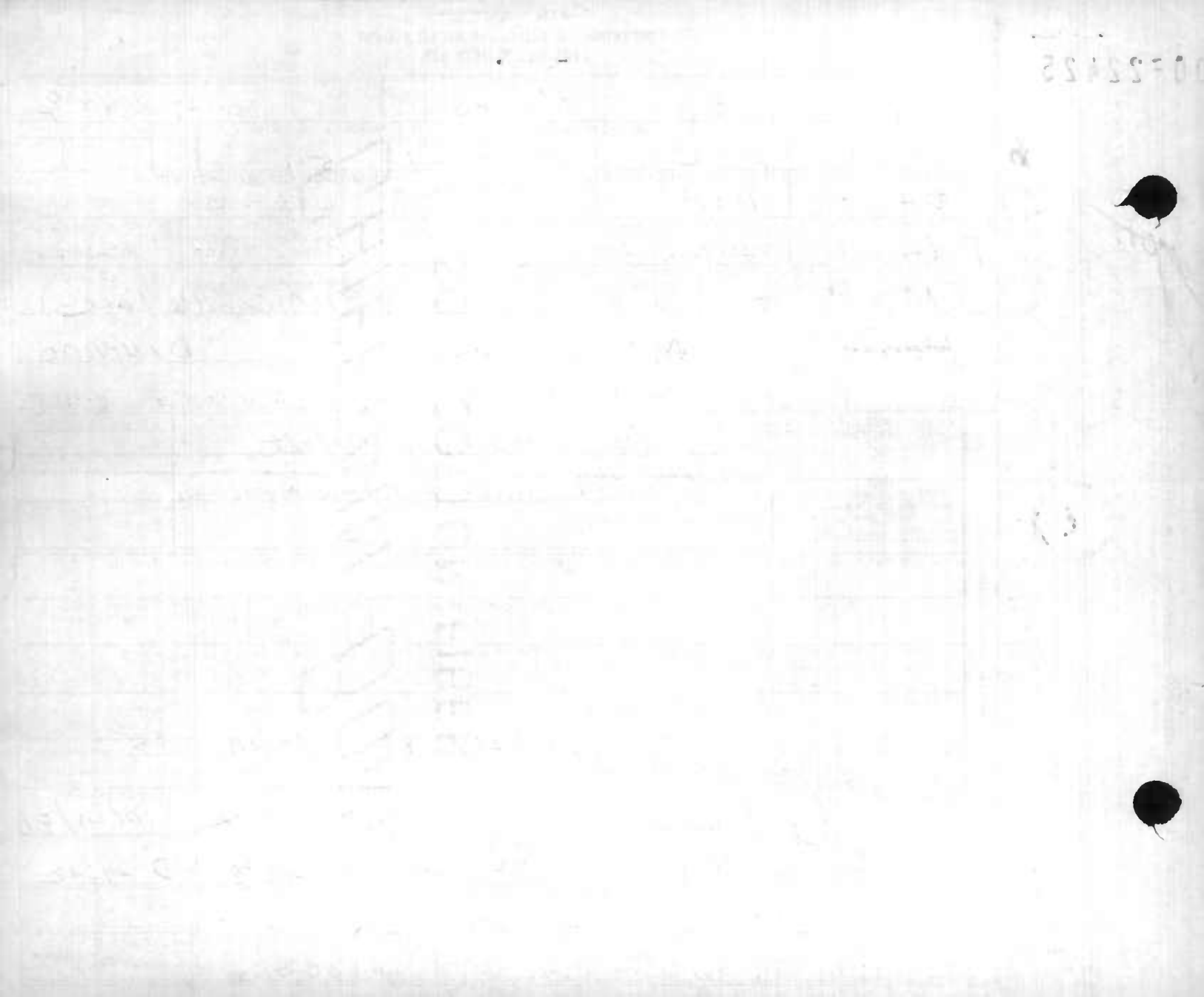
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then detach page 4 and return it to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked as above, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

 1 - FOR  
STATE  
REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Donald</u> <u>E</u> <u>Marino</u>   |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><u>10</u> <u>27</u> <u>86</u>                            |   | 2b HOUR<br><u>6:00</u> A.M.  |
| 3 SEX<br><u>Male</u>  | 4 RACE<br><u>C</u>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>10</u> <u>8</u> <u>27</u>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>59</u> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>PA</u>   | 7b CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                               |   |  |
| 10 CITY OR TOWN OF DEATH<br><u>Baltimore</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University Hospital</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Personnel Office</u>    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Bethlehem</u>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <u>MD</u> 13b COUNTY <u>Balto</u> 13c CITY OR TOWN <u>Balto</u>  |   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>James</u> <u>MARINO</u>   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>ANN</u> <u>DINARDO</u>                      |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>Yes</u> <u>Korea</u>  |   | 16b SOCIAL SECURITY NO.<br><u>184 20 9690</u>  | 17 INFORMANT<br>ADDRESS<br><u>Theresa M. Marino - 8107 Candle Lane-21237</u>                   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>prostate Cancer &amp; diffuse metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |   |  |  |   |  |
| 19a DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/26</u> 19 <u>86</u> to <u>10/27</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Austin</u>   |   | DEGREE   |  | 22c. DATE SIGNED<br><u>10/27/86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>AUSTIN MA</u>   |   | 22e. ADDRESS<br><u>22 S. Greene, Balto, MD 21202</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Entombment</u>   |   | 23b. DATE<br><u>10-30-86</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parkwood Cem.</u>                                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u>   |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>John C. Miller Inc.-6415 Belair Rd.-21206</u>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 28 1986</u>  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the funeral director within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |                       |                                    |                                |  |
|---|--|--|--|---|---|---|-----------------------|------------------------------------|--------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |   |   |                       |                                    |                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH                           |   |                       |                                    |                                |  |
| FIRST MIDDLE LAST<br>David (Baby Boy) Marsh   |  |  |  |   | MONTH DAY YEAR HOUR<br>10 - 17 - 86 1:34 AM |   |                       |                                    |                                |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |                       | 7. IF UNDER 1 YEAR                 |                                |  |
| Male  |  | White  |  | MONTH DAY YEAR<br>10 - 16 - 86  |   | 15 yrs 0 YRS  |                       | MONTHS DAYS HOURS MIN.<br>0 0 18 6 |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                       |                                    |                                |  |
| Maryland  |  | USA  |  |   |   | Baltimore City MD.  |                       |                                    |                                |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                       | 12b. KIND OF BUSINESS OR INDUSTRY  |                                |  |
| Baltimore   |  | Sinai Hospital of Baltimore  |  |   |   | none  |                       | none                               |                                |  |
| 13a. STATE  |  |  |  |   | 13b. COUNTY                                 |   | 13c. CITY OR TOWN     |                                    | 13d. STREET ADDRESS / ZIP CODE |  |
| Maryland  |  |  |  |   | Washington                                  |   | Hagerstown            |                                    | 361 Yorkshire Drive 21740      |  |
| 14. FATHER'S NAME   |  |  |  |   | 15. MOTHER'S MAIDEN NAME                    |   |                       |                                    |                                |  |
| FIRST MIDDLE LAST<br>David Marsh  |  |  |  |   | FIRST MIDDLE LAST<br>Sharon                 |   |                       |                                    |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |   | 16b. SOCIAL SECURITY NO.                    |   | 17. INFORMANT ADDRESS |                                    |                                |  |
| no  |  |  |  |   | none  |   |                       |                                    |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |                       |                                    |                                |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |                       |                                    |                                |  |
| IMMEDIATE CAUSE (a) cardiorespiratory arrest  |  |  |  |   |   |   |                       |                                    |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) persistent fetal circulation   |  |  |  |   |   |   |                       |                                    |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |   |   |                       |                                    |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |   |   |                       |                                    |                                |  |
| 19a. DATE OF OPERATION  |  |  |  |   |   |   |                       |                                    |                                |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |   |   |   |                       |                                    |                                |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |   |   |                       |                                    |                                |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |   |   |                       |                                    |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   |   |   |                       |                                    |                                |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  |   |   |   |                       |                                    |                                |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |   |   |                       |                                    |                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |   |   |   |                       |                                    |                                |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |   |   |   |                       |                                    |                                |  |
| 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |   |   |   |                       |                                    |                                |  |
| 22a. I certify that (1) this hospital attended the deceased from Oct. 16, 1986, to Oct. 17, 1986, that (2) (we) last saw the deceased alive on Oct. 17, 1986, and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did not) view the body after death. |  |  |  |   |   |   |                       |                                    |                                |  |
| 22b. SIGNATURE DEGREE   |  |  |  |   |   |   |                       |                                    |                                |  |
| Esther Y. Johnson MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |  |   |   |   |                       |                                    |                                |  |
| 22c. DATE SIGNED 10-17-86   |  |  |  |   |   |   |                       |                                    |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |   |   |                       |                                    |                                |  |
| Esther Y. Johnson MD  |  |  |  |   |   |   |                       |                                    |                                |  |
| 22e. ADDRESS  |  |  |  |   |   |   |                       |                                    |                                |  |
| Sinai Hospital of Baltimore   |  |  |  |   |   |   |                       |                                    |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |   |   |   |                       |                                    |                                |  |
| cremation   |  |  |  |   |   |   |                       |                                    |                                |  |
| 23b. DATE 10-21-86  |  |  |  |   |   |   |                       |                                    |                                |  |
| 23c. NAME OF CEMETERY OR CREMATORY Sinai Hospital   |  |  |  |   |   |   |                       |                                    |                                |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |   |   |   |                       |                                    |                                |  |
| Baltimore MD  |  |  |  |   |   |   |                       |                                    |                                |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |   |   |   |                       |                                    |                                |  |
| Sinai Hospital 2401 W. BELVEDERE AVE  |  |  |  |   |   |   |                       |                                    |                                |  |
| 25a. DATE REC'D. BY REGISTRAR 10/31/86  |  |  |  |   |   |   |                       |                                    |                                |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |   |   |                       |                                    |                                |  |
| Aria D. Johnson   |  |  |  |   |   |   |                       |                                    |                                |  |

MEDICAL CERTIFICATION

20X COLLOIDAL RUB  
20X COLLOIDAL RUB

175

00-22870

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the bonapapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation. **IMPORTANT:** If item 21 is marked buried or cremated, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO. 8028-11   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Cyril</u> <u>Martin</u>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <u>10</u> <u>28</u> <u>86</u>  |  |   |  | 2b. HOUR <u>11:20</u> <u>PM</u>  |  |
| 3 SEX <u>Male</u>   |  | 4. RACE <u>WHITE</u>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <u>10</u> <u>22</u> <u>02</u>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                      |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>England</u>   |  | 7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> MD.                            |  |  |  |
| 10 CITY OR TOWN OF DEATH <u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Francis Scott Key Medical Center</u> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Assist. Plant</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Super ARC Rods</u>                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u>   |  | 13c. CITY OR TOWN <u>Dundalk</u>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Emmanuel</u> <u>Martin</u>   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ethel</u> <u>Prout</u>   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>  |  |  |  | 16b SOCIAL SECURITY NO. <u>140-10-0486</u>  |  | 17 INFORMANT ADDRESS <u>Gordon Martin 1819 Portship Rd. 21222</u>                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular asystole</u>  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Endstage Ischemic Cardiomyopathy</u>  |  |  |  |   |  |   |  | <u>Sys.</u>  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |  |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)      |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                      |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>10/28/86</u> to <u>10/28/86</u> , that (I) (we) saw the deceased alive on <u>10/28/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b SIGNATURE <u>Theodore Mackinnery</u> MD   |  |  |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED <u>10/29/86</u>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Theodore Mackinnery</u>   |  |  |  | 22e ADDRESS <u>FSKMC 4940 Eastern Ave</u>   |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>10-31-86</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>  |  | 23d LOCATION CITY OR TOWN COUNTY STATE <u>Dundalk</u> <u>Balto.</u> <u>Maryland</u> |  |  |  |
| 24 FUNERAL DIRECTOR NAME <u>DUDA-RUCK FUNERAL HOME OF DUNDALK</u>   |  |  |  | 25a DATE REC'D. BY REGISTRAR <u>NOV - 5 1986</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pedraza</u>                            |  |  |  |

00-55059

BOX COLLOID EPPER



00-21093

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this page and page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 21093  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>HARRY M. MARTIN   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 10 86  |  |
| 3. SEX<br>MALE   |  | 2b. HOUR<br>11:51 AM  |  |
| 4. RACE<br>CAUC.   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>09 18 99  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 72 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOSPITAL               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HARRYMAN   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SEA/LEAST  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTO.   |  |
| 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GEORGE MARTIN   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNIE TRACY   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>HARRYMAN NO  |  | 16b. SOCIAL SECURITY NO.<br>216 10 8711   |  |
| 17. INFORMANT<br>CHAET Mrs. Evaline E. Martin  |  | ADDRESS<br>Same as  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD (Myocardial Infarct.)<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 weeks   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (this hospital) attended the deceased from 9/17, 19 86, to 10/10, 19 86, that (I) (we) last saw the deceased alive on 10/10, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                           |  |   |  |
| 22b. SIGNATURE<br>David J. Rogoski   |  | 22c. DATE SIGNED<br>10/10/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID J. ROGOSKI  |  | 22e. ADDRESS<br>3001 S. HANOVER ST. BALTO. MD 21230   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>10/11/86   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process Crem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Catonsville, Balto. Co. MD   |  |
| 24. FUNERAL DIRECTOR NAME<br>McCully Funeral Home  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 15 1986  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |  |

1

100-5118-00

00-20984

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 28919

|  |  |   |  |   |  |   |  |   |  |                 |  |   |  |
|--|--|---|--|---|--|---|--|---|--|-----------------|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY   |  | YEAR            |  | 2b. HOUR  |  |
|  |  | WILLIAM ROBERT MARTIN   |  | October 11 1986   |  |   |  |   |  |                 |  | 830 PM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                 |  | IF UNDER 24 HRS |  |   |  |
| MALE   |  | WHITE   |  | 8 18 03   |  | 83 YRS.   |  | MONTHS  |  | DAYS            |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                 |  |   |  |
| Maryland   |  | U.S.A.  |  |   |  | Baltimore City  |  |   |  |                 |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                 |  |   |  |
| Baltimore  |  | 506 S. Bentalou Street  |  | Carpenter   |  | Paint Manuf. Co.  |  |   |  |                 |  |   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                             |  |                 |  |   |  |
| Maryland   |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 506 S. Bentalou Street 21223                    |  |                 |  |   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |   |  |                 |  |   |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  |   |  |   |  |   |  |                 |  |   |  |
| William Thomas Martin  |  | Florence Nevada Fish  |  |   |  |   |  |   |  |                 |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                 |  |   |  |
| NO   |  | 218-09-5011   |  | Margaret G. Rohrer  |  | 635 Longview Dr. 21228  |  |   |  |                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |   |  |                 |  |   |  |
|  |  | Bronchogenic Carcinoma  |  | Adenocarcinoma  |  | 12 months   |  |   |  |                 |  |   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |                 |  |   |  |
|  |  |   |  | (c)   |  |   |  |   |  |                 |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                      |  |   |  |   |  |   |  |   |  |                 |  |   |  |
| 9a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |   |  |                 |  |   |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |   |  |                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |                 |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                 |  |   |  |
|  |  |   |  |   |  |   |  |   |  |                 |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from  |  | Nov 27 19 85  |  | to  |  | Death 19  |  | that (I) (we) last<br>saw the deceased alive on |  | Sept 10 19 86   |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |
| above, (I) (we) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |                 |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |   |  |                 |  |   |  |
| Joseph H. Miller MD  |  |   |  |   |  | Oct. 12, 1986   |  |   |  |                 |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |   |  |                 |  |   |  |
| JOSEPH H. Miller MD  |  | 900 CATON AVE Baltimore 21229   |  |   |  |   |  |   |  |                 |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |   |  |                 |  |   |  |
| Burial   |  | 10/15/86  |  | Loudon Park Cemetery  |  | Baltimore Maryland  |  |   |  |                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                 |  |   |  |
| Hubbard Funeral Home, Inc.   |  | 4107 Wilkens Ave.   |  | 21229   |  | OCT 15 1986   |  |   |  |                 |  |   |  |





00-21663

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 28420  
REG. NO.

|  |  |   |   |   |   |  |   |  |  |  |
|--|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN MARTOCCI</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 19, 1986</b>  |   |   | 2b. HOUR<br><b>11:45pm</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 1 1907</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>---</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan ?</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1914 Eastern Ave. 21231</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Piatrowski</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wanda Baginski</b>                                |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>                     |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-18-6930</b>   |  |   | 17. INFORMANT<br>ADDRESS<br><b>D John M. Kozin 4548 Hazelwood Ave. 21206</b>                          |   |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL <del>ISCHEMIA</del> ISCHEMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIOMEGALY WITH CHF</b> |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>OBSTRUCTIVE JAUNDICE; THROMBOCYTOPENIA; HEMORRHAGIC DIASTASIS</b>   |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>OCT. 5, 1986</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>OBST <del>JAUNDICE</del> JAUNDICE; FAILURE</b> |   |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                     |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 5</b> , 19 <b>86</b> , to <b>OCTOBER 19</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 19</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.   |  |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>George A. Tuoma</b>   |  |   |   |   |   | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>10/19/86</b>  |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE A. TUOMA, M.D.</b>  |  |   |   |   |   | 22d. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BAL TIMORE, MD. 21231</b>      |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Oct. 22 '86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Mary</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lilly &amp; Zeiler Inc.</b>   |  |   |   |   |   | ADDRESS<br><b>1901 Eastern Ave. 21231</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1986</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |   |   |   |  |   |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



10/1/10

00-20452

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 4 2 1  
REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN GEORGE MARUSIODIS |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 7, 1986                        |  | 2b. HOUR<br>4:15 <sup>P</sup>                                   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 21 98   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Greece           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Hat maker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dry cleaning          |   |

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |   |   |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>505 S. Clinton Street 21224 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Marusiodis                             |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Evangeline Roros                               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>169-01-8260 | 17. INFORMANT<br>Mrs. Minodora Marusiodis, 505 S. Clinton St. Baltimore, Md. |   |   |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEVERE PNEUMONIA, &amp; SEPSIS</u>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |

|   |  |
|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>INFARCT</u><br><u>ACUTE RESPIRATORY DISTRESS SYNDROME PROBABLE RECURRENT MYOCARDIAL</u> |  |
|---|--|

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |

|   |  |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 8</u> 19 <u>86</u> , to <u>OCTOBER 7</u> 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>OCTOBER 7</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |
|---|--|

|  |   |                  |
|--|---|------------------|
| 22b. SIGNATURE<br><i>Alan Rosenbloom MD.</i>                 | DEGREE  | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALAN ROSENBLOOM MD. | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 North BROADWAY BALTIMORE, MD. 2123 |                  |

|  |                       |   |   |
|--|-----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>10-10-86 | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md. |
|--|-----------------------|---|---|

|   |  |                            |
|---|--|----------------------------|
| 24. FUNERAL DIRECTOR<br>Ann S. Matthews, Matthews Funeral Home<br>3021 Eastern Avenue, Baltimore, Md. 21224 | 25a. DATE REC'D. BY REGISTRAR<br>OCT 09 1986 | 25b. REGISTRAR'S SIGNATURE |
|---|--|----------------------------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove certificate to Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

58100-00

7

00-22448

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 2 8 - 2 2  
REG. NO.

|  |  |   |   |  |  |  |
|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARGARET J. MASON  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 24, 1986 |  | 2b. HOUR<br>12:20A<br>M  |  |
| 3 SEX<br>female  |  | 4 RACE<br>black   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 10 1927                                      |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Va   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59<br>YRS.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Schooled Cleaners  |   |  |  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>BALTO  |   | 13c. CITY OR TOWN<br>Baltimore   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Mason   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jessie Freedman  |   | 13d. STREET ADDRESS / ZIP CODE<br>4620 Mandordene Road Apt. B 21229                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>227-38-0528  |   | 17. INFORMANT<br>ADDRESS<br>Milton McCray 405 Edsdale Street                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE UNDIFFERENTIATED LEUKEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min</u><br><u>3 mos</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>RECURRENT INTRAABDOMINAL ABSCESS</u>  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><u>9/3/86</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>ABSCESS</u>  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 31</u> 19 <u>86</u> , to <u>OCTOBER 24</u> 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>OCTOBER 29</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.              |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>CAROLYN B. HENDRICKS</u>  |  | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>10/24/86</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>CAROLYN B. HENDRICKS</u>   |  | 22e. ADDRESS<br><u>650 N. WOLFE ST. BALTO 21205</u>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>Burial</u>   |  | 23b. DATE<br><u>10/28/86</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cemetery</u>                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>March Funeral Home</u>  |  | ADDRESS<br><u>West 4300 Wabash Avenue</u>   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 28 1986</u>                                  |  |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |  |

BP

50-5842

BOX COTTON FIBRE

162

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-22327

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8028423  
REG. NO.1- FOR  
STATE  
REGISTRAR

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <i>Rene</i> MIDDLE LAST <i>Mason</i> |   |  | 2a. DATE OF DEATH<br>MONTH <i>10</i> DAY <i>16</i> YEAR <i>86</i>               |   | 2b. HOUR<br><i>1830</i> M  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>Caucasian</i>   | 5. DATE OF BIRTH<br>MONTH <i>1</i> DAY <i>9</i> YEAR <i>11</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>75</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.Y.</i>                          | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>County City</i> MD.                                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sinai Hospital of Baltimore</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>NONE</i> | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>NONE</i>  |  |
| 13a. STATE<br><i>Maryland</i>   |   | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <i>UNKNOWN</i> MIDDLE LAST                             |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>UNKNOWN</i> MIDDLE LAST   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i> |   | 16b. SOCIAL SECURITY NO.<br><i>111-16-2036</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>E. VEALE 1114 N. CATHEDRAL</i>                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Electrolyte imbalance*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) *Dehydration*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*2 weeks**2 weeks*PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *NO*

MEDICAL CERTIFICATION

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/9/86</i> , 19____, to <i>10/16/86</i> , 19____, that (I) (we) last<br>saw the deceased alive on <i>10/16/86</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><i>M. Kern</i>   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><i>10/16/86</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Youngmee Kern</i>  |  | 22e. ADDRESS<br><i>c/o Sinai Hospital of Baltimore</i>                         |   |

|   |                              |  |   |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i> | 23b. DATE<br><i>10/25/86</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MT ZION</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTO. MD.</i> |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>BETH'S FUNERAL HOME</i>    |                              | ADDRESS<br><i>1129 N. CAROLINE</i>                   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 27 1986</i>             |
|   |                              | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>     |   |

00-55351



0-21447

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 8 28 24

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST CHARLES MIDDLE ELMER LAST MATHIAS SR.<br><i>Charles E Mathias Sr.</i>   |  | 2a. DATE OF DEATH<br>MONTH 10 DAY 15 YEAR 86<br><i>10 15 86</i>   |  | 2b. HOUR<br>12:57P<br><i>12:57P</i>   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH December DAY 17, YEAR 1932  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Production Planner   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Westinghouse   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Catonsville  |  |
| 14. FATHER'S NAME<br>FIRST Maultin MIDDLE LAST Mathias   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Julia MIDDLE LAST House   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Korean 215-28-1119   |  | 17. INFORMANT<br>Margaret E. Mathias Same as # 13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic lung carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Seizures</i>   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>10/15</i> , 19 <i>86</i> , to <i>10/15</i> , 19 <i>86</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>10/15</i> , 19 <i>86</i> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Barbara Socha</i>   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br><i>10/15/86</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Barbara Socha</i>  |  | 22e. ADDRESS<br><i>900 Caton Ave, Baltimore, MD</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(BY CITY)<br>Burial   |  | 23b. DATE<br>10/17/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1986  |  | 25b. REGISTRAR'S SIGNATURE  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 27 is marked as seen, it states any injury, or other traumatic event, or medical condition that is not notified to the funeral director.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(1)

RECEIVED  
JAN 10 1964  
FBI - NEW YORK

[Faint, mostly illegible text covering the majority of the page, possibly a letter or report.]

00-20702

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |  |  |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>DOROTHY CULLEN MATTHAI  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 8 86                                       |   | 2b. HOUR<br>11:25 A.M.   |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 13, 1895   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.                          |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KESWICK NURSING HOME |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |  |
| 13a. STATE<br>MD  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3501 St. Paul St., 21218 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John A. Cullen  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Shields   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219 10 6142  |  | 17. INFORMANT ADDRESS<br>Joseph F. Matthai, Jr., Balto., MD                          |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic cardio-vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>May 26</u> , 19 <u>85</u> , to <u>October 8</u> , 19 <u>86</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>October 8</u> , 19 <u>86</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>M. Isabelle MacGregor</u>  |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  |  |   | 22c. DATE SIGNED<br>10-8-86  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M-ISABELLE MACGREGOR   |  |   |  | 22e. ADDRESS<br>KESWICK, 700 W. 40th Street, Balto. Md 21211  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |   | 23b. DATE<br>10/9/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 01 1986   |   |  |  |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28-20  
REG. NO.

|  |              |   |   |   |  |  |  |
|--|--------------|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARIZ MIDDLE Young LAST MATTHEWS  |              |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 27 86                             |   |  | 2b. HOUR<br>1 10 A M   |  |
| 3. SEX<br>F  | 4. RACE<br>B | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 27 01 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                                  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Cumberland, Md  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA           |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO - CITY MD.   |              |   | 10. CITY OR TOWN OF DEATH<br>BALTO.   |   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KESWICK |              |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TEACHER |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |

|   |  |             |  |  |  |   |  |
|---|--|-------------|--|--|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2034 McCullah ST. 21217 |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 4. FATHER'S NAME<br>FIRST CHARLES MIDDLE H. LAST HUNG |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MARY MIDDLE BATES LAST |  |  |
|---|--|--|--|--|--|

|  |  |                          |  |                        |  |         |  |
|--|--|--------------------------|--|------------------------|--|---------|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT<br>CHART |  | ADDRESS |  |
|--|--|--------------------------|--|------------------------|--|---------|--|

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Central vascular disease with CVA?</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 days<br>1 year |  |
|--|--|---|--|

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|                        |  |   |   |
|------------------------|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|---|---|

|  |  |  |
|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|--|--|--|

|  |  |   |
|--|--|---|
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |
|--|--|---|

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|                                   |              |                              |
|-----------------------------------|--------------|------------------------------|
| 22b. SIGNATURE<br>S. H. WELSON MD | DEGREE<br>MD | 22c. DATE SIGNED<br>10.27.86 |
|-----------------------------------|--------------|------------------------------|

|                                       |              |
|---------------------------------------|--------------|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---------------------------------------|--------------|

|   |                       |  |  |
|---|-----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(BY) | 23b. DATE<br>10/31/86 | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. ZION CEMT. | 23d. LOCATION<br>BALTIMORE COUNTY MD STATE |
|---|-----------------------|--|--|

|   |  |  |
|---|--|--|
| 24. FUNERAL DIRECTOR<br>PHILLIPS FUNERAL HOME | 25a. DATE REC'D. BY REGISTRAR<br>OCT 30 1986 | 25b. REGISTRAR'S SIGNATURE<br>J. W. WARDEN |
|---|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove complete pages 1 and 2 and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial. Removal of this certificate after the funeral home has been notified is a violation of the law. If item 21 is marked or item 18 shows any injury, or other information, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

8 REG. NO. 284227

|  |  |   |  |   |   |  |   |   |  |  |
|--|--|---|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PERCY NATTHEWS Sr.</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10/7/86</b>                     |   |   | 2b. HOUR<br><b>7:42A.M.</b>  |   |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12/9/99</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                                    |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                              |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>2243 W. Baltimore St. 21223</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>? ? ?</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>? ? ?</b>  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>215-05-1553</b>                         |   | 17. INFORMANT ADDRESS<br><b>Martha Norriss 764 W. Hamburg St. 21230</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Lolena L. Cuenca</b> DEGREE   |  |   |  |   |   | 22c. DATE SIGNED<br><b>10/7/86</b>   |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CEPUVINA C. CUETO</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>Liberty WEIGHS MEDICAL CTR<br/>LUTHERAN HOSPITAL - PREVIOUSLY</b> |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>10/11/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>                                |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice FSPA</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 08 1986</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |
| ADDRESS<br><b>1300 Eutaw Place</b>   |  |   |  |   |   |  |   |   |  |  |

BP \_\_\_\_\_

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REC'D. 28 4 28

|  |                         |  |  |   |  |
|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Tyronia Matthews</b>   |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 : 08 : 86</b>   |  | 2b. HOUR<br><b>9:00 P.M.</b>  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br><b>2/22/ 1889</b> YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>97</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mississippi</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.   |                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hospital</b> |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                    |  |
| 13b. COUNTY  |                         | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bishop Austin</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Austin</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>214-56-9936</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Rosie Dartez 2101 Allendale Rd.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>pseudomembranous colitis</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>organic brain syndrome</b>   |                         |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>10/14/86</b>  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/1/81</b> 19 <b>86</b> to <b>10/8/86</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>10/8/86</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |                         |  |  |   |  |
| 22b. SIGNATURE<br><b>K. DESAI</b>  |                         | DEGREE   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. DESAI</b>   |                         | 22e. ADDRESS<br><b>North Charles General Hospital Baltimore</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>10/14/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Nat. Mem Pk.</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel P.G. Md.</b>   |                         | 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles A. Rice FSPA 1300 Eutaw Pl,</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>   |  |
| 25b. REGISTRAR'S SIGNATURE   |                         |  |  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this must be included in the report.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, &amp; 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

ADDITIONAL



0-21151

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 8 2 2 2

 1- FOR  
STATE  
REGISTRAR

|  |  |                  |                 |  |  |  |  |   |               |  |  |   |  |   |                          |                                   |  |
|--|--|------------------|-----------------|--|--|--|--|---|---------------|--|--|---|--|---|--------------------------|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Kenton |  |  | MIDDLE<br>(NMN)  |  |   | LAST<br>Mayer |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 13 19 86 |  |   | 2b. HOUR<br>M 1:25A<br>M |                                   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR 10/16/49  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |               | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 10 13 19 86               |  | 2d. HOUR<br>M 1:25A<br>M  |  |   |                          |                                   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Connecticut   |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |                          |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |  |  |  |   |               |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dental Technician Health           |  |   |                          | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br>Maryland   |  |                  |                 | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |               | 13e. STREET ADDRESS<br>328 Folcroft St. 21224                        |  |   |  |   |                          |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gustav Mayer   |  |                  |                 |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Ellen Chambers                 |  |   |               |  |  |   |  |   |                          |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>ADDRESS<br>Mary E. Wetteman 3402 Treeridge Hwy Alpharetta, GA 30201 |  |   |               |  |  |   |  |   |                          |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <u>Smoke inhalation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |                  |                 |  |  |  |  |   |               |  |  |   |  |   |                          |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |                  |                 |  |  |  |  |   |               |  |  |   |  |   |                          |                                   |  |
| 19a. DATE OF OPERATION   |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |               |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>12:55xx 10 13, 86   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>House fire   |               |  |  |   |  |   |                          |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>328 Folcroft St. Balto. MD.  |               |  |  |   |  |   |                          |                                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |                 |  |  |  |  |   |               |  |  |   |  |   |                          |                                   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |  |                  |                 | TITLE (SPECIFY)<br>Assistant   |  |  |  | MEDICAL EXAMINER  |               |  |  | DATE SIGNED<br>10/13/86   |  |   |                          |                                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |  |                  |                 | ADDRESS<br>111 Penn St. Balto. MD.   |  |  |  |   |               |  |  |   |  |   |                          |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |                  |                 | 23b. DATE<br>10/16/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Atlanta Crematory                              |  |   |               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Atlanta Fulton Georgia |  |   |  |   |                          |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MacNabb Funeral Home Balto., MD 21228  |  |                  |                 | 25a. DATE REC'D. BY REGISTRAR<br>OCT 16 1986   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |               |  |  |   |  |   |                          |                                   |  |



023343 NOV 10 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28430

|   |         |  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
|---|---------|--|--|---|--|---|--|--|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| MARY  |         | ALICE  |  | MAYERS  |  |   |  | <input checked="" type="checkbox"/>    |  | 10-27-86                 |  | 19    |  |      |  | M        |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                       |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| FEMALE  | BLACK   | 8 18 1913  |  | 73 YRS.   |  |   |  |  |  | 10-27-86                 |  | 19    |  |      |  | 8:05a    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                          |  |       |  |      |  |          |  |
| S. Carolina   |         | U. S. A.   |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | Baltimore City  |  |  |  |                          |  |       |  |      |  | MD       |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                          |  |       |  |      |  |          |  |
| Baltimore   |         | 1300 E. Lanvale St. Apt. 305   |  | DOMESTIC  |  | PVT. Families   |  |  |  |                          |  |       |  |      |  |          |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                    |  |                          |  |       |  |      |  |          |  |
| MARYLAND  |         |  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 21213 (Lanvale Towers)                 |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| JAKE R. JAMES   |         | ESTHER GAMBLE  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                          |  |       |  |      |  |          |  |
| No.   |         | 212-14-5175  |  | Miss Miami Beach, Florida 33139   |  | Amani Ayers 1775 Washington Ave. Apt. 12E                           |  |  |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:                          |         | IMMEDIATE CAUSE (a)  |  | Arteriosclerotic hypertensive cardiovascular  |  | disease   |  |  |  |                          |  |       |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                     |         | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | (c)   |  |  |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. |         |  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH               |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                    |         | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  | Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)   |  | DATE SIGNED                            |  | 10-27-86                 |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE  |         | M.D. Assistant   |  | MEDICAL EXAMINER  |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | Gregory R. Kauffman, M.D.  |  | ADDRESS   |  | 111 Penn Street   |  |  |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |                          |  |       |  |      |  |          |  |
| Burial  |         | 11/01/86   |  | Mt. Auburn Cemetery   |  | Baltimore, Maryland   |  |  |  |                          |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| Nutter & Sons Funeral Home, Inc.<br>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216  |         | NOV - 6 1986   |  | Alia Fisher-Randall   |  |   |  |  |  |                          |  |       |  |      |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH PAGE 1, 2, 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

07/84  
25MDHMH - 17  
(VR A15 ME (5))

SLICE

U. S. A. 1913 73

U. S. A. 1913 73

DOMESTIC  
P.T. Families  
(Lanvale Town)  
1900 A. Lanvale Street, Apt. 302

PAINTING

James  
Father  
Miss  
1775 Washington Ave. Apt. 12  
Garden  
212-14-2175  
No.

2501 Guyton Falls Pkwy. Baltimore, Md. 21216  
Worster & Sons Funeral Home, Inc.  
Mt. Auburn Cemetery  
Baltimore, Maryland

00-20492

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO. 28-31

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Langdon Philip McAninch Sr.</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 7 1986</b>  |  | 2b. HOUR<br><b>3:30</b> P.M.   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 29 1906</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Missouri</b>   |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret - Mechanic</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State of MD</b>   |  | 13a. STREET ADDRESS / ZIP CODE<br><b>6401 Liberty Rd. 21207</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles William McAninch</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ada Dudley</b>  |  | 16. SOCIAL SECURITY NO.<br><b>579-14-9867A</b>   |  |
| 17. INFORMANT'S NAME<br>FIRST MIDDLE LAST<br><b>Mrs. Gertrude McAninch</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis of ? origin</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alzheimer's ?</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 22a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 22b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 22c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 23a. I certify that (I) (this hospital) attended the deceased from <b>9/3/86</b> to <b>10/7/86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death. |  | 23b. SIGNATURE<br><b>E. Abesada</b>   |  | 23c. DATE SIGNED<br><b>10/7/86</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers Funeral Directors, Inc.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 09 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| 26. BURIAL, CREMATION, REMOVAL<br><b>Entombment</b>  |  | 27. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mausoleum</b>  |  | 28. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium Baltimore Maryland</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and submitted to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed by a medical examiner.

NOTION 6302

11/11/11

USA Library/Book Development, August 2013  
Library/Book Development, August 2013  
Library/Book Development, August 2013



00-20488

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 28432

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM J. MCCARTHY</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 7, 1986</b>  |   | 2b. HOUR<br><b>6:25 AM</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 21 04</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>82</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fire Chief-Fire Dept.-Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Howard</b>   | 13c. CITY OR TOWN<br><b>Ellicott City</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          | 13e. STREET ADDRESS / ZIP CODE<br><b>Ellicott City, Md.<br/>3235-S North Chatham Rd. #21043</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William F. McCarthy</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Barlow</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-40-5993</b>  |  | 17. INFORMANT<br><b>Mrs. Ruth D. McCarthy</b> City, Md. #21043                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic dysrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>myocardial infarction</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>seconds</b><br><b>hours</b><br><b>hours</b>                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CONTRIBUTING TO DEATH</b>  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 06, 1986</b> to <b>October 07, 1986</b> , that (I) (we) last saw the deceased alive on <b>October 07, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Lucy R. Sutphen MD</b>   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/7/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lucy R. Sutphen MD</b>  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>   |  | 23b. DATE<br><b>Oct. 10, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 09 1986</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. THOMAS SCHWAB</b>   |  | ADDRESS<br><b>5151 BALTO. NAT'L. PIKE - #21229</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

00-30483

1

20% COTTON FIBRE

00-20194

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REC'D NO. 2 8 3 3

1. FOR  
STATE  
REGISTRAR

|  |                              |   |   |                          |                                      |   |                 |                                   |                 |   |
|--|------------------------------|---|---|--------------------------|--------------------------------------|---|-----------------|-----------------------------------|-----------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              | FIRST   | MIDDLE  | LAST                     | 2a. DATE OF DEATH                    | MONTH   | DAY             | YEAR                              | 2b. HOUR        | P |
| Emily  |                              | M.  |   | McCauley                 | 10                                   | 4   | 1986            |                                   | 6:30            | M |
| 3. SEX   | 4. RACE                      |   | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | IF UNDER 1 YEAR |                                   | IF UNDER 24 HRS |   |
| Female   | White                        |   | 8 MONTH 28 DAY 1900 YEAR  |                          | 86 YRS                               |   | MONTHS          |                                   | DAYS            |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                 |                                   |                 |   |
| Md.  | USA                          |   |   |                          | Baltimore City                       |   |                 |                                   | MD              |   |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                          |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                 | 12b. KIND OF BUSINESS OR INDUSTRY |                 |   |
| Baltimore  |                              | Edgewood Nursing Home   |   |                          |                                      | Homemaker   |                 |                                   |                 |   |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                              | 13b. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? |                                      | 13e. STREET ADDRESS / ZIP CODE                                      |                 |                                   |                 |   |
| Md   |                              | Balto   |   | Rogers Forge             |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | 426 Overbrook Rd. 21212           |                 |   |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME  |   |                          |                                      |   |                 |                                   |                 |   |
| FIRST MIDDLE LAST  |                              | FIRST MIDDLE LAST   |   |                          |                                      |   |                 |                                   |                 |   |
| Wm.  |                              | Kuszmaul  |   | Lavenia Tawney           |                                      |   |                 |                                   |                 |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                   |                              | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS    |                                      |   |                 |                                   |                 |   |
| no   |                              | 212 50 2743   |   | Mrs Walter McCauley Same |                                      |   |                 |                                   |                 |   |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Acute Cardiovascular event, prob. arrhythmia</i>       |  |   |  |
| (c) <i>Inoperable Carcinoma Gall Bladder</i>  |  |   |  |

|   |   |  |  |
|---|---|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.                        |   |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
|   |   |  |  |

|   |  |                                    |  |
|---|--|------------------------------------|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-12 1986</i> to <i>10-4 86</i> , that (I) (we) last saw the deceased alive on <i>9-12 1986</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I <del>was not</del> did not) view the body after death. |  | 22c. DATE SIGNED                   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | 22c. DATE SIGNED<br><i>10-5-86</i> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS                       |  |
| Veniedo Alidio M.D.   |  | 6010 York Rd.                      |  |

|  |           |   |  |
|--|-----------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| Burial                                       | 10/8/1986 | Baltimore National Cemt                                 | Baltimore Md                               |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS         |           | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |  |
| Mitchell Wiedefeld Home 6500 York Rd.        |           | OCT 07 1986   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-22439

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, page 1, and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28434

|   |   |   |  |   |
|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IDA (NMN) MCCAULEY</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 23, 1986</b>   |  | 2b. HOUR<br><b>3 PM</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 27, 1988</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b><br>YRS MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |
| 13a. STATE<br><b>MARYLAND</b>   |   | 13b. COUNTY<br><b>ANNE Arundel</b>  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>  | 13d. INSIDE CITY LIMITS?<br>Y <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Aloysius (NMN) Sitter</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline (NMN) Heerzog</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  | 17. INFORMANT ADDRESS<br><b>Mrs. Diana Gardner (granddaughter) 1185 Annis Squam Harbor, Pasadena 21122</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GRAM NEGATIVE SHOCK (SEPTIC)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>KLEBSIELLA PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>METABOLIC ACIDOSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ALZHEIMER'S DISEASE</b>  |   |   |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/18</b> , 19 <b>86</b> , to <b>10/23</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>10-23</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |
| 22b. SIGNATURE<br><b>Patricia Steadman</b>  | DEGREE<br><b>M.D.</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED<br><b>10-23-86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA S STEADMAN</b>   |   | 22e. ADDRESS<br><b>3001 SOUTH HANOVER ST BALTIMORE 21230</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Oct. 27 1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balt. National Cem</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Singleton Funeral Home</b>   |   | ADDRESS<br><b>Glen Burnie Maryland</b>  | 25a. DATE REC'D. BY REGISTRAR<br><b>00148 1986</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |

BP

REF 86

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

30-155-00

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 NO 28435

|  |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
|--|---------|--|--|---|--|---|--|---|--|---|--|-----------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | MONTH                                     |  | DAY             |  | YEAR  |  | 2b. HOUR                                     |  |
| DANIEL   |         | McClain  |  | McCLAIN   |  | McCLAIN   |  | 10-23-86  |  | 10  |  | 23              |  | 86  |  | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD                  |  | MONTH           |  | DAY   |  | YEAR   |  |
| male   | black   | 7 17 1908  |  | 78 YRS.   |  |   |  |   |  | 10-23-86                                  |  | 10              |  | 23  |  | 86   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |                 |  |   |  |  |  |
| N.C.   |         | USA  |  | WIDOWED   |  | DIVORCED  |  | Baltimore City  |  |   |  |                 |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |   |  |                 |  |   |  |  |  |
| Baltimore  |         | 3507 Greenspring Avenue                                  |  | Retired   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |  |                 |  |   |  |  |  |
| Md   |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3507 Greenspring Avenue 21211   |  |   |  |                 |  |   |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| Daniel   |         | Pipcan   |  | Adalai  |  | McClain   |  |   |  |   |  |                 |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |   |  |                 |  |   |  |  |  |
| Yes  |         | 243-18-7751  |  | Melvin R. Jones 308   |  | E 23rd Street   |  |   |  |   |  |                 |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost   |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| (c)  |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |  |   |  |   |  |                 |  | 20. AUTOPSY?  |  |  |  |
|  |         |  |  |   |  |   |  |   |  |   |  |                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                 |  |   |  |  |  |
|  |         |  |  | P.M. 19   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |                 |  |   |  |  |  |
|  |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| ACTUAL SIGNATURE Margarita A. Korell   |         |  |  |   |  |   |  |   |  | TITLE (SPECIFY) Assistant                 |  |                 |  | DATE 10-24-86   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.  |         |  |  |   |  |   |  |   |  | MEDICAL EXAMINER                          |  |                 |  | SIGNED  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation  |         |  |  |   |  |   |  |   |  |   |  |                 |  |   |  |  |  |
| 23b. DATE 10/24/86   |         |  |  | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Cemetery |  |   |  | 23d. LOCATION CITY OR TOWN Catonsville  |  |   |  | COUNTY STATE Md |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME March Funeral Home West 4300 Wabash Avenue   |         |  |  |   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR OCT 28 1986 |  |                 |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

0-22447

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FD-350



00-21660

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28436

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |  |  |   |  |   |  |                  |  |   |  |
|--|---------|--|--|--|--|---|--|---|--|------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |  | X MONTH DAY YEAR |  | 2b. HOUR  |  |
| Carolyn Ann McComas  |         |  |  |  |  |   |  | 10/ 17/19 86  |  |                  |  | 10:56 A M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD  |  | MONTH DAY YEAR   |  | 2d. HOUR  |  |
| Female   | White   | May 4 1945   |  | 41 YRS.  |  |   |  | 10/ 17/19 86  |  |                  |  | A M   |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                  |  |   |  |
| Maryland   |         | U.S.A.   |  |  |  | Baltimore City,   |  |   |  |                  |  | MD  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                  |  |   |  |
| Baltimore  |         | Francis Scott Key Med. Center  |  | Asst. Manager  |  | First Nat'l Bank of Md.   |  |   |  |                  |  |   |  |
| 13a. STATE   |         | 13b. CITY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                  |  |   |  |
| Maryland   |         | Harford  |  | Havre de Grace   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 903 Quarry Rd., Havre deGrace, Md.  |  |                  |  | 21078   |  |
| 14. FATHER'S NAME  |         | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE  |  | LAST             |  |   |  |
| Cardiff  |         | N.   |  | McComas, Jr.   |  | Claire Erma Goodrich  |  |   |  |                  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |                  |  |   |  |
| No   |         | 216-44-1877  |  | J. Richard McComas, Aberdeen, Maryland   |  |   |  |   |  |                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Gunshot Wounds of Head<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |  |  |  |  |   |  |   |  |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |         |  |  |  |  |   |  |   |  |                  |  |   |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                  |  | 20. AUTOPSY?  |  |
|  |         |  |  |  |  |   |  |   |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br>1:30 P.M. 10/ 14/19 86  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot |  |                  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Lewis Lane & Rt. 40, Havre DeGrace, Md.  |  |                  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |  |  |   |  |   |  |                  |  |   |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |   |  | DATE SIGNED   |  |                  |  | 10/18/86  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  |  | ADDRESS  |  |   |  |   |  |                  |  |   |  |
| William M. Zane, M.D.  |         |  |  | 111 Penn St.   |  |   |  |   |  |                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial   |         |  |  | Oct. 21, 1986  |  |   |  | Mountain Christian Church Cemetery  |  |                  |  | Joppa Harford Maryland  |  |
| 23e. DATE REC'D. BY REGISTRAR  |         |  |  | 23f. REGISTRAR'S SIGNATURE   |  |   |  |   |  |                  |  |   |  |
| OCT 21 1986  |         |  |  | Lee A. Patterson & Son, Perryville, Maryland   |  |   |  |   |  |                  |  |   |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1 TO THE FUNERAL DIRECTOR. PAGE 2 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PIN. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 42 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH 17  
(VR A15 ME (5))

00-1500

C

00-21811

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                  |                 |  |  |  |  |   |      |   |  |   |  |  |                          |  |  |
|---|--|------------------|-----------------|--|--|--|--|---|------|---|--|---|--|--|--------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  | FIRST<br>YVONNE |  |  | MIDDLE<br>MCCOY  |  |   | LAST |   |  | DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>10 20 19 86 |  |  | 2b. HOUR<br>M<br>1:40 AM |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 23 53   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>32 YRS.                          |  | IF UNDER 1 YR.<br>MONTHS DAYS   |      | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10 20 19 86         |  |  | 2d. HOUR<br>M<br>1:40 AM |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                             |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.        |  |  |                          |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                      |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Key Medical Center |  |  |  |   |      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nursing home                   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>- |                          |  |  |
| 13a. STATE<br>MD  |  |                  |                 |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>21213<br>1825 Freedomway North             |  |  |                          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Harris                      |  |                  |                 |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mattie Barey Jones    |  |   |      |   |  |   |  |  |                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No |  |                  |                 |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-58-7225 |  | 17. INFORMANT<br>ADDRESS<br>Leon A. McCoy 2230 Aiken St.  |      |   |  |   |  |  |                          |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Subarachnoid hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) Ruptured berry aneurysm

DUE TO, OR AS A CONSEQUENCE OF

(c) Blunt head trauma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Hypertension

|                        |  |   |  |   |  |
|------------------------|--|---|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|---|--|---|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10-20-1986        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Subject struck in face and subsequently fell. |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1825 Freedom Way North, Balto. City MD                                    |  |

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.

|  |  |  |  |                         |  |
|--|--|--|--|-------------------------|--|
| ACTUAL SIGNATURE<br><i>Charles P. Kokes</i>                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER |  | DATE SIGNED<br>10-20-86 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Charles P. Kokes, M.D. |  | ADDRESS<br>111 Penn St., Balto., MD 21201          |  |                         |  |

|   |  |                       |  |  |  |   |  |
|---|--|-----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                        |  | 23b. DATE<br>10-24-86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Homes 1101 E. North Ave |  |                       |  | 25a. DATE REC'D BY REGISTRAR<br>OCT 23 1986          |  | 25b. REGISTRAR'S SIGNATURE                              |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

11815-00

✓ JALH. MOTOC. No. 2  
20% COTTON FIBRE

00-20322

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28438  
REG. NO.

|   |  |   |  |   |   |  |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mollie C. MCCUBBIN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 4 86                         |   |   | 2b. HOUR<br>1355 M   |  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 5 18   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ of Md |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Packer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Glass Company   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>1415 S. Carey Street, 21230      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Roos  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian Blockinger    |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-03-3608  |  | 17. INFORMANT<br>ADDRESS<br>Charles Franklin, 1415 S. Carey Street  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Intra-abdominal infection, Pelvic Abscess</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |   |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> 19 <u>86</u> , to <u>10/4</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>10/4/86</u> , and that an (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.  |  |   |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>John Hughes MD</u>   |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/4/86  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Hughes  |  |   | 22e. ADDRESS<br>Univ of Md Hosp  |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>10/8/86   |   | 23c. NAME OF CEMETERY OR CREMATOR<br>Glen Haven Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Md. |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.,   |  |   |  |   | ADDRESS<br>21229 4107 Wilkens Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 08 1986                       |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Hughes</u> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SEP 85 28

00-1038



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. **86 28439**

1. STATE 10/7/86 rja  
REGISTRAR

|   |   |  |  |  |   |
|---|---|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GLADYS Mae McCULLOUGH</b>            |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>09/30/86</b>                             |  | 2b. HOUR <b>10P.M.</b>                                  |
| 3. SEX <b>F</b>   | 4. RACE <b>B</b>  | 5. DATE OF BIRTH MONTH DAY YEAR <b>07/29/24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>63 62</b> YRS.  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>                         | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GEN</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |
| 13a. STATE <b>MD</b>  |   | 13b. COUNTY  | 13c. CITY OR TOWN <b>CITY</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIE ALLEN</b>                     |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLOSSIE Mae COLLINS</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> |   | 16b. SOCIAL SECURITY NO. <b>213264022</b>  |  | 17. INFORMANT ADDRESS <b>Vertina Campbell 1804 Riggs Avenue</b>                              |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Breast Carcinoma</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY, YEAR P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/11</b> 19 <b>86</b> to <b>9/30</b> 19 <b>86</b> that (I) (we) lost saw the deceased alive on <b>9/30</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE <b>W. Rahming</b>   |  | DEGREE <b>M-D</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>9/30/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAHMING</b>   |  | 22e. ADDRESS <b>3001 S. HANOVER ST. 21230</b>  |  |   |   |

|   |                          |   |   |
|---|--------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                             | 23b. DATE <b>10/4/86</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b> | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co Md</b> |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>March Funeral Home West 4300 Wabash Avenue</b> |                          | 25a. DATE REC'D. BY REGISTRAR <b>OCT 02 1986</b>              | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                     |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PEP 85 48

12710



00-21255

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |   |   | 86 NO. 28440   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>PATRICIA F. MCCUTCHEN  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10/11/86                 |  |   | 2b. HOUR<br>7:05 PM  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>04 12 31   |  | 6. AGE IN YEARS (LAST BIRTHDAY)<br>55 YRS  |   | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                          |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSP. OF BALT |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES PERSON        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>COWARD SHOE   |  |  |
| 13a. STATE<br>MARYLAND  |  |   |   |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MATTHEW LYNCH  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>HATTIE PURNELL |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO.  |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>214-26-3614                      |  | 17. INFORMANT ADDRESS<br>JOHN W. McCUTCHEN 1614 N HILTON ST. BALTO, MD. 21216 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MASSIVE CEE BRAINSTEM &amp; HEMISPHERIC INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>DISSECTING ANEURYSM OF AORTA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>HTN</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>PRIOR CVA</u>  |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/08/86</u> , 19 <u>86</u> , to <u>10/11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, then (I) (did not) view the body after death.)  |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Richard J. Segal</u>   |  |   |   |   | DEGREE<br>M.D.   |  |   | 22c. DATE SIGNED<br>10/11/86   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD J. SEGAL   |  |   |   |   | 22e. ADDRESS<br>SINAI HOSP. OF BALT.                         |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>10/16/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON FOREST VET.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD.                     |  |  |  |
| 24. FUNERAL HOME OR OTHER PERSON TO WHOM REMAINS WERE DELIVERED<br>NUTTER + SONS FUNERAL HOME, INC.<br>2501 GWYNNS FALLS PKWY. BALTO, MD. 21216   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1986   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28441  
REV. NO.

1 - FOR  
STATE  
REGISTRAR

|                                     |        |        |        |                   |       |      |      |          |
|-------------------------------------|--------|--------|--------|-------------------|-------|------|------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) | FIRST  | MIDDLE | LAST   | 2b. DATE OF DEATH | MONTH | DAY  | YEAR | 2b HOUR  |
|                                     | Esther | E.     | McGill | OCTOBER           | 16    | 1986 |      | 12:15 PM |

|        |         |                          |                                 |                 |      |                  |      |
|--------|---------|--------------------------|---------------------------------|-----------------|------|------------------|------|
| 3. SEX | 4. RACE | 5. DATE OF BIRTH         | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR |      | IF UNDER 24 HRS. |      |
| Female | White   | MONTH DAY YEAR<br>2 2 24 | 62 YRS                          | MONTHS          | DAYS | HOURS            | MIN. |

|  |   |   |   |
|--|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>California</b> | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY <u>OR</u> COUNTY OF DEATH<br><b>Baltimore</b> |
|--|---|---|---|

|   |  |   |  |
|---|--|---|--|
| 10. CITY OR TOWN OF DEATH<br>Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>The Union Memorial Hospital | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher | 12b. KIND OF BUSINESS OR INDUSTRY<br>Music |
|---|--|---|--|

|   |             |                   |  |                                |
|---|-------------|-------------------|--|--------------------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |             |                   |  |                                |
| 13a. STATE  | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?                                 | 13e. STREET ADDRESS / ZIP CODE |
| Md.   |             | Balto.            | YES <input type="checkbox"/> NO <input type="checkbox"/> | 223 E. Northern Pkwy. 21212    |

|                   |                          |
|-------------------|--------------------------|
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST        |
| Elmer Ebersole    | Clara Mabel Breneman     |

|   |                         |                     |               |
|---|-------------------------|---------------------|---------------|
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) | 16b SOCIAL SECURITY NO. | 17 INFORMANT        | ADDRESS       |
| No  | 564-26-1906             | Mr. Glenn W. McGill | - Same as #13 |

|  |                                      |   |
|--|--------------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>RESPIRATORY &amp; CARDIAC ARREST</u>  |                                      | <u>1 MINUTE</u>                                 |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  | DUE TO, OR AS A CONSEQUENCE OF       |   |
|  | (b) <u>CARCINOMATOSIS OF ABDOMEN</u> | <u>MONTHS</u>                                   |
|  | DUE TO, OR AS A CONSEQUENCE OF       |   |
|  | (c) <u>PANCREATIC CARCINOMA</u>      | <u>MONTHS - 2 YEARS</u>                         |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

|               |                              |  |  |  |   |  |   |  |
|---------------|------------------------------|--|--|--|---|--|---|--|
| CERTIFICATION | 19a DATE OF OPERATION<br>N/A |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|               | NONE                         |  |  |  |   |  |   |  |

|   |  |  |
|---|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>N/A |
|---|--|--|

|       |  |  |                         |              |        |       |
|-------|--|--|-------------------------|--------------|--------|-------|
| MEDIC | 21d. INJURY OCCURRED   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET | CITY OR TOWN | COUNTY | STATE |
|       | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT HOME |  | n/a                     |              |        |       |

72a. I certify that (u) (his hospital) attended the deceased from October 11, 1986, to October 16, 1986, that (u) (we) last saw the deceased alive on October 16, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) did (did not) view the body after death.

|   |              |  |                              |
|---|--------------|--|------------------------------|
| 77b. SIGNATURE<br><i>Richard P. Frank</i> | DEGREE<br>MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 77c. DATE SIGNED<br>10/16/86 |
| 77d. PHYSICIAN'S NAME (PRINT)             | 77e. ADDRESS |  |                              |

|                                      |                             |
|--------------------------------------|-----------------------------|
| 17b PHYSICIAN'S NAME (Type or print) | 17c ADDRESS                 |
| Richard P. Franklin, M.D.            | The Union Memorial Hospital |

|   |                             |                                   |                              |        |       |
|---|-----------------------------|-----------------------------------|------------------------------|--------|-------|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b> | 23b DATE<br><b>10-16-86</b> | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION<br>CITY OR TOWN | COUNTY | STATE |
|---|-----------------------------|-----------------------------------|------------------------------|--------|-------|

|   |  |  |
|---|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board | 25. DATE RECEIVED BY REGISTRAR<br>ADDRESS<br>Balto., Md. | 26. REGISTRAR'S SIGNATURE<br>OCT 27 1986<br>Julia Davidson-Randall |
|---|--|--|

MEDICAL CERTIFICATION

2

7

22362

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be filed against.

PPPS 33

3385-1

WINTER  
MOUNTAIN



00-22904

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28442

REG. NO.

|   |  |  |   |   |  |  |                                   |  |
|---|--|--|---|---|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |   |  | 2b. HOUR   |                                   |  |
| JOHN MCGINTY  |  |  | OCTOBER 31, 1986  |   |  | 12:15 P  |                                   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   |  | 7. IF UNDER 1 YEAR   |                                   |  |
| Male  | White  | Aug. 3, 1965   | 21 YRS  |   |  | MONTHS DAYS HOURS MIN.   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |                                   |  |
| PENNA   | U.S.A  |  |   | BALTIMORE CITY MD.  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL   |  |   | Student   |  |  | School                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. INSIDE CITY LIMITS?  |   |  | 13c. STREET ADDRESS / ZIP CODE   |                                   |  |
| PENNA. Lebanon  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |  | 1237 E. 1st St. 17042  |                                   |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |   |  |  |                                   |  |
| Michael J. McGinty  |  |  | RITA MULLAN   |   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT  |                                   |  |
| No  |  |  | 201-50-3848   |   |  | 126 S. 9th Street, Lebanon, PA. 17042  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) CARDIAC ARREST  |  |  |   |   |  |  |                                   | 30 minutes   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hyperkalemia   |  |  |   |   |  |  |                                   | 26 hours   |
| DUE TO, OR AS A CONSEQUENCE OF (c) Acute Renal Failure  |  |  |   |   |  |  |                                   | 3 days   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |   |  |  |                                   |  |
| Hyperammonemia secondary to bone marrow transplant for Hodgkins lymphoma  |  |  |   |   |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |   |  |  |                                   |  |
|   |  |  | P.M. 19   |   |  |  |                                   |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION  |                                   |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   |   |  | CITY OR TOWN COUNTY STATE  |                                   |  |
| 22a. I certify that (this hospital) attended the deceased from 10/4/86 to 10/31/86, that (we) last saw the deceased alive on 10/31/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (by we did) (did not) view the body after death. |  |  |   |   |  |  |                                   |  |
| 22b. SIGNATURE  |  |  | DEGREE  |   |  | 22c. DATE SIGNED   |                                   |  |
| R. N. DuBois  |  |  | MD  |   |  | 10/31/86   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |   |  |  |                                   |  |
| R. N. DuBois  |  |  | 600 N. Wolfe St. Johns Hopkins Hospital                             |   |  | BALTO. MD 21205  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  |  | 23b. DATE   |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |  |
| Burial  |  |  | 11/3/86   |   |  | Holy Cross   |                                   |  |
| 23d. LOCATION   |  |  | 23e. NAME OF CEMETERY OR CREMATORY                                  |   |  | 23f. LOCATION  |                                   |  |
| Lebanon   |  |  | Lebanon   |   |  | Lebanon PA.  |                                   |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |
| Raymond Russell McWitzke  |  |  | 11/03/86  |   |  | Julia Gordon-Randall   |                                   |  |

JAN 1 1 P.M.

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20/00/80

80 55 55 P 4

00-22661

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. 86 28443  |  |                     |  |
|---|--|---|--|---|--|---|--|---|--|--|--|---------------------|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>McKay, Saul G. (Saul G. McKay)   |  |   |  |   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/15/86  |  | 2b. HOUR<br>7:50 PM |  |
| 3. SEX<br>M   |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 6 86   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>9 days YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>0 9                                     |  | IF UNDER 24 HRS.<br>HOURS MIN.<br>0 0  |  |                     |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |  |   |  |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U. of Md. Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NIA   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>NIA                                  |  |  |  |                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland  |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>909 Wicklow Rd. 21229                   |  |  |  |                     |  |
| 14. FATHER'S NAME<br><del>McKay</del> SAUL MCKAY  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Natalie A. Harry  |  |   |  |   |  |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR IN FOREIGN SERVICE)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>NIA   |  | 17. INFORMANT ADDRESS   |  |   |  |  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac and Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF Disseminated Intravascular Coagulopathy<br>(b) <del>EMBO</del><br>DUE TO, OR AS A CONSEQUENCE OF Probable overwhelming sepsis<br>(c)     |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |  |  |                     |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/15/86 AM 7:49 PM 19 10/15/86 to 7:50 PM 10/15 19 86, that (I) (we) last saw the deceased alive on 10/15/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |                     |  |
| 22b. SIGNATURE<br>Elaine Trogon, M.D.   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/15/86  |  |  |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elaine Trogon, M.D.  |  |   |  |   |  | 22e. ADDRESS<br>22 S. Greene St. Balt., Md.   |  |   |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal   |  |   |  | 23b. DATE<br>10-23-86   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d.  |  |  |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board   |  |   |  |   |  | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1986                              |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |                     |  |

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the signature of the attending physician. The funeral director, after this certificate has been signed by the attending physician and completed, should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR 18 & 22 per M.E. 11/14/86  
 1- STATE REGISTRAR 1,5,8,15,17 Film G622 127 307 800-45  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28444  
 76

|   |  |                         |  |  |  |   |  |  |  |
|---|--|-------------------------|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Bennie (McLemore)</b>   |  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>10 14 1986</b>                         |  |   |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 7 40</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>45 YRS.</b>  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TENNESSEE</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>836 Park Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES</b>  |  |
| 13a. STATE<br><b>MD</b>   |  |                         |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George McLemore</b>  |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Juanita Sims</b>   |  |   |  | 16. ADDRESS<br><b>Simms</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>411-64-0690</b>  |  | 17. INFORMANT<br><b>Sims</b><br><b>Juanita Simms 135 Longfellow St. NW</b>                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Narcotic Intoxication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                         |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                         |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>10 14 1986</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject was drugged</b> |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>836 Park Ave. Balt. MD</b>                          |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |                         |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>William M. Zane</b>   |  |                         |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>   |  |   |  | DATE SIGNED <b>10/15/86</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>William M. Zane, M.D.</b>   |  |                         |  | ADDRESS <b>111 Penn St. Balto., MD.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |                         |  | 23b. DATE<br><b>10/21/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ZION HILL</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Kingsport TENNESSEE</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEREOY O DYETT &amp; SON 4600 Liberty Hgts.</b>  |  |                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MDHMH - 17  
(VR A15 ME (5))



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

28445

FOR  
STATE  
REGISTRAR

|  |                              |   |   |                                     |                                      |   |                 |   |                                   |                                  |  |
|--|------------------------------|---|---|-------------------------------------|--------------------------------------|---|-----------------|---|-----------------------------------|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              | FIRST   | MIDDLE  | LAST                                | 2a. DATE OF DEATH                    |   | MONTH           | DAY   | YEAR                              | 2b. HOUR                         |  |
| NELLIE JANE MCLAUGHLIN   |                              |   |   |                                     | October 10, 1986                     |   |                 |   |                                   | 5:15 A.M.                        |  |
| 3. SEX   | 4. RACE                      |   | 5. DATE OF BIRTH  |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | IF UNDER 1 YEAR |   | IF UNDER 24 HRS                   |                                  |  |
| Female   | White                        |   | February 2, 1986  |                                     | 100                                  |   | MONTHS DAYS     |   | HOURS MIN.                        |                                  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                 |   |                                   |                                  |  |
| Virginia   | U.S.A.                       |   |   |                                     | Baltimore City MD.                   |   |                 |   |                                   |                                  |  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                     |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)      |                 |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                  |  |
| Baltimore  |                              | Meridian Nursing Home   |   |                                     |                                      | Homemaker   |                 |   | Home                              |                                  |  |
| 13a. STATE   |                              |   |   | 13b. COUNTY                         |                                      | 13c. CITY OR TOWN   |                 | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS / ZIP CODE   |  |
| Maryland   |                              |   |   | Howard                              |                                      | Ellicott City   |                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 3256J Normandy Woods Drive 21043 |  |
| 14. FATHER'S NAME  |                              |   |   | 15. MOTHER'S MAIDEN NAME            |                                      |   |                 |   |                                   |                                  |  |
| FIRST MIDDLE LAST<br>Nathaniel Lloyd   |                              |   |   | FIRST MIDDLE LAST<br>Rose (unknown) |                                      |   |                 |   |                                   |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |                              |   |   | 16b. SOCIAL SECURITY NO.            |                                      | 17. INFORMANT   |                 |   |                                   |                                  |  |
| No   |                              |   |   | 216-28-9788D                        |                                      | 3256-J Normandy Woods Dr.<br>Edgar Hearn Sr. Ellicott City, MD. 21043 |                 |   |                                   |                                  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CVD.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GENERALIZED ARTERIOSCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>15 yrs</u><br><u>20 yrs</u> |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>80</u> , to <u>10/10</u> , 19 <u>86</u> , that (I) (we) last<br>saw the deceased alive on <u>10/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Norman R. Kleiman</u> M.D.                        |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br><u>10/11/86</u>                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |
| Norman R. Kleiman M.D.   |  | 3803 Edmondson Avenue, Baltimore, MD. 21229                            |  |  |  |   |  |

|  |  |           |  |                                    |  |  |  |
|--|--|-----------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial                                       |  | 10/13/86  |  | Lorraine Park                      |  | Woodlawn Maryland                          |  |

|   |  |                               |  |   |  |
|---|--|-------------------------------|--|---|--|
| 24. FUNERAL DIRECTOR<br><u>Leroy M. &amp; Russell C. Witzke</u> Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228 |  | 25a. DATE REC'D. BY REGISTRAR |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson</u> |  |
|   |  | OCT 14 1986                   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified.

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28446  
REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Robert McLeod  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCT 17 1986                          |  | 2b. HOUR<br>3:30 P   |
| 3. SEX<br>male   | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>AUG 8 1924  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>South Carolina   | 7b. CITIZEN OF WHAT COUNTRY?<br>US  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen Hosp |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles McLeod   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Daisy Chapman              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219 169851   | 17. INFORMANT<br>ADDRESS<br>Helen McLeod 865 Bethune Rd 21225               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary insufficiency  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| DUE TO, OR AS A CONSEQUENCE OF,<br>(b) metastatic Bronchogenic CA of lung  |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/14, 1986, to 10/17, 1986, that (I) (we) last saw the deceased alive on 10/17, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>Harold Blumenthal, MD  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>10/17/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold Blumenthal MD  |   | 22e. ADDRESS<br>3001 S HANOVER ST Baltimore   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>10-22-86   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON FOREST   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>OWINGSMILLS MD                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MARCH F/H 1101 E. NORTH AVE.   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1986  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-22275

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28447  
REG. NO.

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROSELLA</b>  |  |  | FIRST MIDDLE LAST  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 22 86</b>  |  |  | 2b. HOUR<br>MIN. <b>5:32 Am</b>  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 25 09</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>N. Charles Hosp.</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>--</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b>  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>401 N. Loudon Ave. 21229</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-86-0041</b>   |  |  | 17. INFORMANT<br><b>Ms. Annie M. Owens - same as #13</b>  |  |  | ADDRESS  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCIAL ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SQUAMOUS CELL CA OF TONGUE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SEPSIS</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>10/9/86</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>SQUAMOUS CELL CA</b>  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/21</b> 19 <b>86</b> , to <b>10/22</b> 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>10/22</b> 19 <b>86</b> , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.              |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>CHES</b>   |  |  |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>         |  |  | 22c. DATE SIGNED<br><b>10/22/86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRANCIS CHES MD</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>3100 WYOMING AVE. CR.</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Removal</b>   |  |  | 23b. DATE<br><b>10-22-86</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1986</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rudman</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then, please give the permit, this certificate, and the death certificate to the funeral director. The funeral director should be detached for use on the burial-transit permit. Then, please give the permit, this certificate, and the death certificate to the funeral director. The funeral director should be detached for use on the burial-transit permit. Then, please give the permit, this certificate, and the death certificate to the funeral director.

IMPORTANT: If item 21 is marked on item 18 above any injury, or a traumatic event, the medical examiner must be notified at once.

BP

TPPSS

00-2222





00-21034

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 28448  
REG. NO.

|  |  |  |   |   |  |  |  |   |  |   |  |
|--|--|--|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Gilbert H. McQuay</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 9, 1986</b> |   | 2b. HOUR<br>M<br><b>AM</b>   |  |  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 11, 1909</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>77</b><br>YRS MONTHS DAYS MIN.   |  |   |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b><br>MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3208 Lawnview Avenue</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tobacco Ret. Chief of Alcoholic &amp;</b> |  | 12b. TYPE OF BUSINESS OR INDUSTRY<br><b>Ret. State of Md</b> |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3208 Lawnview Avenue 21206</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Patrick Henry McQuay</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Ridgeway</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-26-4245</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Margaret E. McQuay Same</b>   |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA PROSTATE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10/84</b><br><b>TO</b><br><b>10/9/84</b>     |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 1973</b> to <b>OCT. 1986</b> , that (I) (we) last saw the deceased alive on <b>9/1/85</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Francis X. Carmody MD</b>   |  |  |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/10/86</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Francis X. Carmody MD</b>  |  |  |   | 22e. ADDRESS<br><b>201 E. University Pkwy Balto. Md.</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Oct. 13, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Gockeysville Balto. Md.</b>   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>William H. Hurdell</b>  |  |   |  |   |  |

MEDICAL CERTIFICATION

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BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

October 9, 1956

Mr. J. Edgar Hoover  
Director  
Federal Bureau of Investigation  
Washington, D. C.

Dear Sir:

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

Very truly yours,  
J. Lee Rankin  
Special Agent in Charge

Enclosure - 2 copies

Very truly yours,  
J. Lee Rankin

Enclosure - 2 copies

Very truly yours,  
J. Lee Rankin

00-22932

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7-84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
Gertrude May McWilliams CERTIFICATE OF DEATH

86

REG. NO.

28449

|  |  |   |   |   |  |  |   |  |  |
|--|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GERTRUDE MAY MCWILLIAMS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 30 86</b>                    |   |  | 2b. HOUR<br><b>3:45 AM</b>   |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 19 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>72</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME MAKER</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>ANNE ARUNDEL</b>  |   | 13c. CITY OR TOWN<br><b>PASADENA</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE GEYER</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GERTRUDE M. BURNS</b> |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>    |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-07-0574</b>   |  |   | 17. INFORMANT<br>ADDRESS<br><b>Millard A. McWilliams</b>                  |   |  | 17b. Same as 13e   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>   |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>-0-</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION, PERSISTENT VEGETATIVE STATE</b>  |  |   |   |   |  |  |   | <b>5 WEEKS</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MULTIPLE CEREBROVASCULAR INCIDENTS</b>  |  |   |   |   |  |  |   | <b>7 WEEKS</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>DIABETES, HYPERTENSION</b>  |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 7</b> , 19 <b>86</b> , to <b>OCT 30</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>OCT 30</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Peter H. Gorman MD</b>  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>10/30/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER H. GORMAN</b>  |  |   |   |   | 22e. ADDRESS<br><b>22 S. GREENE ST BALT, MD 21210</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11/1/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |  | 23d. LOCATION<br><b>Baltimore</b> COUNTY <b>MD</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce</b>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. Gorman</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP



00-21404

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG 28450

|  |  |  |  |   |  |   |  |   |  |                           |  |                            |  |                                |  |           |  |
|--|--|--|--|---|--|---|--|---|--|---------------------------|--|----------------------------|--|--------------------------------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH ESTI-<br>MATED |  | MONTH                     |  | DAY                        |  | YEAR                           |  | 2b. HOUR  |  |
| Edward   |  | Le Roy   |  | Meadows   |  | Sr.   |  | <input checked="" type="checkbox"/>       |  | 10-10                     |  | 1986                       |  |                                |  | 8:30 P.M. |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                                  |  | IF UNDER 1 YR.<br>MONTHS                  |  | IF UNDER 24 HRS.<br>HOURS |  | MIN.                       |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | 2d. HOUR  |  |
| MALE   |  | WHITE  |  | 10 17 1923  |  | 62 YRS.   |  |   |  |                           |  |                            |  | 10-10 1986                     |  |           |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                           |  |                            |  |                                |  |           |  |
| KENTUCKY   |  | USA  |  |   |  | Baltimore City, MD.   |  |   |  |                           |  |                            |  |                                |  |           |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |   |  |                           |  |                            |  |                                |  |           |  |
| Baltimore  |  | University Hospital - STU  |  | Farmer  |  | Farm  |  |   |  |                           |  |                            |  |                                |  |           |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                       |  |                           |  |                            |  |                                |  |           |  |
| MD   |  | FREDERICK  |  | THURMONT  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 509 WOODLAND AVE., THURMONT, MD           |  |                           |  |                            |  |                                |  |           |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |  |                           |  |                            |  |                                |  |           |  |
| ROY  |  | LELAND   |  | MEADOWS   |  | CLARA   |  | OLIVE                                     |  | KEGLEY                    |  |                            |  |                                |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                           |  |                            |  |                                |  |           |  |
| NO   |  | N/A  |  | 220-34-5809   |  | Margaret Meadows  |  | 509 Woodland Ave.                         |  |                           |  |                            |  |                                |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Injuries with complications</u><br>8150<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |   |  |   |  |   |  |                           |  |                            |  |                                |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |   |  |   |  |   |  |                           |  |                            |  |                                |  |           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |   |  |                           |  |                            |  |                                |  |           |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |                           |  |                            |  |                                |  |           |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR <u>2:40</u> P.M. MONTH <u>10</u> DAY <u>2</u> YEAR <u>1986</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |                           |  |                            |  |                                |  |           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY                                    |  | STATE                     |  |                            |  |                                |  |           |  |
|  |  | road   |  | Rt. 806 south of Kelly Stone Road   |  | Frederick   |  | Frederick                                 |  | MD                        |  |                            |  |                                |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |   |  |   |  |   |  |                           |  |                            |  |                                |  |           |  |
| ACTUAL<br>SIGNATURE  |  | TITLE (SPECIFY)<br>Assistant   |  | M.D.  |  | MEDICAL EXAMINER  |  | DATE<br>SIGNED                            |  | 10-11-86                  |  |                            |  |                                |  |           |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | Charles P. Kokes, M.D.   |  | ADDRESS   |  | 111 Penn St., Balto., Md.   |  | 21201                                     |  |                           |  |                            |  |                                |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                                    |  | STATE                     |  |                            |  |                                |  |           |  |
| BURIAL   |  | 10/15/86   |  | Resthaven Mem. Gardens  |  | Frederick   |  | Frederick                                 |  | MD                        |  |                            |  |                                |  |           |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | G. DOUGLAS STAUFFER  |  | ADDRESS   |  | 1621 Opossumtown Pike, Frederick, MD                                |  | 25a. DATE REC'D. BY REGISTRAR             |  | OCT 16 1986               |  | 25b. REGISTRAR'S SIGNATURE |  |                                |  |           |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN PLACE OF THE WORD "DECEASED". GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. LONG WITH FORM PM-3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



00-22419

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28451  
REG. NO.

|   |  |  |  |   |        |   |                  |                               |     |  |         |
|---|--|--|--|---|--------|---|------------------|-------------------------------|-----|--|---------|
| 1- FOR STATE REGISTRAR  |  | 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST   | MIDDLE | LAST  | 2a DATE OF DEATH | MONTH                         | DAY | YEAR   | 2b HOUR |
|   |  | Anna Marie Mertz   |  |   |        |   | 10               | 28                            | 86  |  | 7:00 A  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |        | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |                  | IF UNDER 1 YEAR               |     | IF UNDER 24 HRS.                             |         |
| Female  |  | White  |  | May 22, 1897  |        | 89  |                  | YRS                           |     | MONTHS DAYS HOURS MIN.                       |         |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                  |                               |     |  |         |
| Maryland  |  | U.S.A.   |  |   |        | Baltimore City  |                  |                               |     | MD.  |         |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |        | 12b KIND OF BUSINESS OR INDUSTRY                                    |                  |                               |     |  |         |
| Baltimore City  |  | The Union Memorial Hospital  |  | Homemaker   |        |   |                  |                               |     |  |         |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b COUNTY   |  | 13c CITY OR TOWN  |        | 13d INSIDE CITY LIMITS?   |                  | 13e STREET ADDRESS / ZIP CODE |     |  |         |
| Maryland  |  |  |  | Baltimore   |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  | 4706 Hampnett Avenue          |     | 21214  |         |
| 14 FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |        | 16b SOCIAL SECURITY NO.   |                  | 17 INFORMANT                  |     | ADDRESS                                      |         |
| Robert  |  | Davidson   |  | unknown   |        | No  |                  | George Mertz                  |     | same as 13e                                  |         |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (b) <u>Severe vascular disease</u>  |        | DUE TO, OR AS A CONSEQUENCE OF                                      |                  | (c)                           |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |        |   |                  |                               |     |  |         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe Pancreatitis</u>   |  |  |  |   |        |   |                  |                               |     |  |         |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?  |        | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |                  |                               |     |  |         |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |        | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                  |                               |     |  |         |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |        |   |                  |                               |     |  |         |
|   |  | P.M. 19  |  |   |        |   |                  |                               |     |  |         |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION STREET   |        | CITY OR TOWN  |                  | COUNTY                        |     | STATE  |         |
|   |  |  |  |   |        |   |                  |                               |     |  |         |
| 22a I certify that (I) (this hospital) attended the deceased from <u>10/26/86</u> , 19 <u>86</u> , to <u>10/28</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>10/28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |        |   |                  |                               |     |  |         |
| 22b SIGNATURE <u>Chris Conyer</u>   |  | DEGREE <u>MD</u>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |        | 22c DATE SIGNED <u>10/28/86</u>                                     |                  |                               |     |  |         |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e ADDRESS  |  |   |        |   |                  |                               |     |  |         |
|   |  | The Union Memorial Hospital  |  |   |        |   |                  |                               |     |  |         |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY   |        | 23d LOCATION CITY OR TOWN   |                  | COUNTY                        |     | STATE  |         |
| Burial  |  | 10/31/1986   |  | Parkwood Cemetery   |        | Baltimore, Maryland   |                  |                               |     |  |         |
| 24 FUNERAL DIRECTOR NAME  |  | 24b ADDRESS  |  | 25a DATE RECD BY REGISTRAR  |        | 25b REGISTRAR'S SIGNATURE   |                  |                               |     |  |         |
| Leonard J. Ruck, Inc. Baltimore, Maryland   |  |  |  | OCT 29 1986   |        |   |                  |                               |     |  |         |

MEDICAL CERTIFICATION

229

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1/2

1-23-1

NOTION  
WATER



George J. Luck, Inc., Baltimore, Maryland  
The Library, Maryland



00-21583

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose this on papers. Pages 1 and 2 should be turned within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86  
REG. NO.

28452

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GRACE Edith MICKEN</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/15/86</b>  |  | 2b HOUR<br><b>12:57 PM</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 23, 1904</b>  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                    |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>N.J.</b>  |  | 10b CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 10c NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital Balto MD</b> |  |
| 11a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary,</b>   |  | 11b KIND OF BUSINESS OR INDUSTRY<br><b>Whiting</b>   |  |   |  |
| 12a STREET ADDRESS / ZIP CODE<br><b>770A Hudson Parkway, Whiting</b>   |  | 12b INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 13a FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ralph Bradford</b>  |  | 13b MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                |  |   |  |
| 14a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 14b SOCIAL SECURITY NO.<br><b>152-05-1681</b>  |  | 14c INFORMANT<br>ADDRESS<br><b>Mr. George Micken, Same as above</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable Cardiac arrhythmia</b>  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Hypertension</b>   |  |  |  |   | <b>years</b>   |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Hypercholesterolemia</b>   |  |  |  |   | <b>years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>   |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 19c AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 19d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 20b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10/15/86</b>                              |  | 20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21a INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21b PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21c LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>10/15/86</b> to <b>10/15/86</b> , that (I) (we) lost saw the deceased alive on <b>10/15/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |  |  |   |  |
| 22b SIGNATURE<br><b>Hyun Joseph Kim MD</b>   |  | DEGREE<br><b>MD</b>  |  | 22c DATE SIGNED<br><b>10/15/86</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HYUN JOSEPH Kim</b>   |  | 22e ADDRESS<br><b>Mercy Hospital, Balto MD 21202</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b DATE<br><b>10/16/86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Security Process,</b>   |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Balto. Co. Md.</b>  |  |  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral</b>  |  | 24b ADDRESS<br><b>Balto. Md. 21202</b>   |  | 24c DATE REC'D. BY REGISTRAR<br><b>OCT 20 1986</b>  |  |
| 25b REGISTRAR'S SIGNATURE  |  |  |  |   |  |



0-20771

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |  |
|--|--|---|--|--|--|--|--|---|--|--|
| 1- FOR STATE REGISTRAR   |  | 86 28453  |  |  |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CURTIS ALFONSO MILLER   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 09, 1986   |  |  | 2b. HOUR<br>7 P.M.  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>08/21/00   |  | 6 AGE (IN YEARS [LAST BIRTHDAY])<br>86 YRS                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>338 Kane Street |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tire Manuf.  |  |  |
| 13a. STATE<br>Md   |  |   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore               |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br>338 Kane Street 21224  |  |   |  |  |  |  |  |   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Charles Robert Miller  |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lizzie Wilson   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> W.W.I  |  |   | 16b. SOCIAL SECURITY NO.<br>233-09-0090                            |  | 17 INFORMANT<br>Sandra Miller  |  |  | ADDRESS<br>338 Kane Street  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic prostate cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Michael Brave MD</u>  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>10/13/86  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL BRAVE   |  |   |  |  | 22e. ADDRESS<br>Key Medical Center   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>10/13/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn Mem. Garden  |  | 23d. LOCATION<br>Sykesville, Howard Co., Md. |   |  |  |
| 24. FUNERAL DIRECTOR<br>Charles S. Zeiler & Son Inc.   |  |   |  |  | ADDRESS<br>6224 Eastern Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1986 |   |  |  |
|  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Landon   |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These papers, together with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal to the funeral home, should be filed within 72 hours after death.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 28454

REG. NO.

| 1. DECEASED NAME  |                   | 2a. DATE OF DEATH   |                | 2b. HOUR   |                |
|---|-------------------|---|----------------|--|----------------|
| (TYPE OR PRINT)   | FIRST MIDDLE LAST | MONTH DAY YEAR  | MONTH DAY YEAR | MONTH DAY YEAR   | MONTH DAY YEAR |
| JOHN MILLER   |                   | 10 5 86   |                | 1150 AM  |                |
| 3. SEX  |                   | 4. RACE   |                | 5. DATE OF BIRTH   |                |
| MALE  |                   | WHITE   |                | MONTH DAY YEAR   |                |
|   |                   |   |                | 4 9 18   |                |
| 6. AGE (IN YEARS LAST BIRTHDAY)                               |                   | 7. BALTIMORE CITY OR COUNTY OF DEATH                            |                | 8. IF UNDER 1 YEAR   |                |
| 68 YRS  |                   | BALTIMORE CITY  |                | MONTHS DAYS HOURS MIN.   |                |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                      |                   | 10. CITY OR TOWN OF DEATH                                       |                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |                |
| Md.   |                   | BALTIMORE   |                | FRANCIS SCOTT KEY MEDICAL CENTER   |                |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                   | 12b. KIND OF BUSINESS OR INDUSTRY                               |                | 13. STREET ADDRESS / ZIP CODE  |                |
| Retired Steel Worker  |                   |   |                | 3434 Wallford Dr. 21222  |                |
| 14. FATHER'S NAME   |                   | 15. MOTHER'S MAIDEN NAME  |                | 16. SOCIAL SECURITY NO.  |                |
| FIRST MIDDLE LAST   |                   | FIRST MIDDLE LAST   |                | 214 037481   |                |
| William MILLER  |                   | Ella C FINNERTY   |                |  |                |
| 17. INFORMANT   |                   | 18. CAUSE OF DEATH  |                | 19. DATE OF OPERATION  |                |
| MICHAEL J. MILLER -   |                   | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST |                | 9-17-86  |                |
| JOPPA, MD. 21085  |                   | DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE BLEEDING DISORDER     |                | Cholecystectomy  |                |
|   |                   | DUE TO, OR AS A CONSEQUENCE OF (c) LIVER DISEASE                |                | 20. AUTOPSY?   |                |
|   |                   |   |                | YES [X] NO [ ]   |                |
|   |                   |   |                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |                |
|   |                   |   |                | YES [ ] NO [X]   |                |
|   |                   |   |                | 21. TIME OF INJURY   |                |
|   |                   |   |                | HOUR A.M. MONTH DAY YEAR   |                |
|   |                   |   |                | P.M. 19  |                |
|   |                   |   |                | 22. I certify that (I) (this hospital) attended the deceased from 9-16-86 to 10-5-86, that (I) (we) lost                         |                |
|   |                   |   |                | saw the deceased alive on 10-5-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |                |
|   |                   |   |                | above, (I) (we) (did) (did not) view the body after death.   |                |
|   |                   |   |                | 22b. SIGNATURE   |                |
|   |                   |   |                | DEGREE   |                |
|   |                   |   |                | 22c. DATE SIGNED   |                |
|   |                   |   |                | 10-5-86  |                |
|   |                   |   |                | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                |
|   |                   |   |                | JAMES SCHUMACHER   |                |
|   |                   |   |                | 22e. ADDRESS   |                |
|   |                   |   |                | JOHNS HOPKINS HOSPITAL   |                |
|   |                   |   |                | DEPT OF SURGERY BALTIMORE, MARYLAND  |                |
|   |                   |   |                | 23. NAME OF CEMETERY OR CREMATORY  |                |
|   |                   |   |                | Sacred Heart of Jesus  |                |
|   |                   |   |                | 23b. DATE  |                |
|   |                   |   |                | 10-9-86  |                |
|   |                   |   |                | 23c. LOCATION  |                |
|   |                   |   |                | CITY OR TOWN COUNTY STATE  |                |
|   |                   |   |                | BALTIMORE, MARYLAND  |                |
|   |                   |   |                | 24. FUNERAL DIRECTOR   |                |
|   |                   |   |                | NAME   |                |
|   |                   |   |                | Dabrowski Funeral Home, Baltimore, Md.   |                |
|   |                   |   |                | 25. DATE OF DEATH  |                |
|   |                   |   |                | OCT 14 1986  |                |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN FIELD 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86

28455

|  |        |  |                   |   |                     |  |          |
|--|--------|--|-------------------|---|---------------------|--|----------|
| 1- FOR STATE REGISTRAR   |        | 2a. DATE KNOWN OF DEATH  |                   | MONTH DAY YEAR  |                     | 2b. HOUR   |          |
| 1. DECEASED NAME (TYPE OR PRINT)   |        | FIRST MIDDLE LAST  |                   | 10 6 1986   |                     | M  |          |
| Keith James Miller   |        |  |                   |   |                     |  |          |
| 3 SEX  | 4 RACE | 5. DATE OF BIRTH   | 6 AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.    | 7c. DATE PRONOUNCED DEAD   | 7d. HOUR |
| Male   | White  | MONTH DAY YEAR   | LAST BIRTHDAY     | MONTHS DAYS HOURS MIN   |                     | 10 6 1986  | 1:40     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |        | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9 BALTIMORE CITY OR COUNTY OF DEATH  |          |
| Maryland   |        | U.S.A.   |                   |   |                     | Baltimore City MD  |          |
| 10 CITY OR TOWN OF DEATH   |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                            |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                     | 12b. KIND OF BUSINESS OR INDUSTRY  |          |
| Baltimore  |        | University Hospital (STU)  |                   | Student   |                     | School   |          |
| 13a. STATE   |        | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS | 21136  |          |
| Md.  |        | Balto.   | Reisterstown      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 232 Tidyman Rd.     |  |          |
| 14 FATHER'S NAME   |        | 15 MOTHER'S MAIDEN NAME  |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |                     | 16b. SOCIAL SECURITY NO.   |          |
| James A. Miller, Jr.   |        | Rosemary Klitch  |                   | No  |                     | 216-72-2764  |          |
| 17. INFORMANT  |        | ADDRESS  |                   | 17. INFORMANT   |                     | ADDRESS  |          |
| James A. Miller, Jr.   |        | 232 Tidyman Rd.  |                   | James A. Miller, Jr.  |                     | Reisterstown, Md.  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |        | PART 1 DEATH WAS CAUSED BY:  |                   | IMMEDIATE CAUSE (a)   |                     | GUESS AT CAUSE OF DEATH  |          |
|  |        |  |                   | Gunshot wound of head (handgun)   |                     |  |          |
|  |        |  |                   | DUE TO, OR AS A CONSEQUENCE OF  |                     |  |          |
|  |        |  |                   | (b)   |                     |  |          |
|  |        |  |                   | DUE TO, OR AS A CONSEQUENCE OF  |                     |  |          |
|  |        |  |                   | (c)   |                     |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |        |  |                   |   |                     |  |          |
| 19a. DATE OF OPERATION   |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                   | 20. AUTOPSY?  |                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |        | 21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                     |  |          |
|  |        | 7:50 P.M. 10 5 1986  |                   | self inflicted  |                     |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                      |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                   | 21f. LOCATION   |                     |  |          |
|  |        | home   |                   | 232 Tidyman Rd, Reisterstown, Balto.MD.   |                     |  |          |
| 22a. I certify that I took charge of the remains described above, held an  |        | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                   | death resulted from:  |                     | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |          |
| ACTUAL SIGNATURE   |        | TITLE (SPECIFY)  |                   | DATE SIGNED   |                     | 10/7/86  |          |
| EXAMINER'S NAME  |        | ADDRESS  |                   | MEDICAL EXAMINER  |                     |  |          |
| William M. Zane, M.D.  |        | 111 Penn St. Balto.MD.   |                   |   |                     |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |        | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY  |                     | 23d. LOCATION  |          |
| Cremation  |        | Oct. 9, 1986   |                   | Westview Mem. Park  |                     | Baltimore, Maryland  |          |
| 24. FUNERAL DIRECTOR   |        | NAME   |                   | ADDRESS   |                     | 25a. DATE REC'D. BY REGISTRAR  |          |
| A. G. Eichle   |        |  |                   | Owings Mills, Md.   |                     | OCT 9 1986   |          |
| 25b. REGISTRAR'S SIGNATURE   |        |  |                   |   |                     |  |          |



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